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EDITORIAL

MEDICINE AND THE HUMANITIES

LESLIE E. DAUGHERTY, M.D.

"I am a part of all that I have met."
—Alfred Lord Tennyson

Modern living calls for intellectual minds, that can view a single problem against the whole pattern of life.

The breadth of vision must take into consideration the body, soul and mind.

The humanities—history, music, art, philosophy and medicine, must come up for critical consideration and review.

How well the medical graduate is grounded in the humanities, determines the future of medicine as an art, as a science and yet as a philosophy.

Early history of the teaching in America, was based entirely on precepts of the Old World. Roman and English, not to mention intermixes, determined America's education. The first schools were based entirely on Theology. Not until 1756, did one University add mathematics, physics, economics and medicine to its curriculum, in America.

Today, industry is demanding and assisting Universities in a broad "look in" into education in general and science, in particular.

How can we as medicine, a fundamental instrumentality of science, mark time in the race for existence, let alone progress in the humanities?

Without fingerpointing, we must search for a thorough systematic evaluation of medical education, not only to perpetuate the science, but the philosophy of our entire humanities.

A healthy nation is a requisite, but a sound mind cognizant of the need is paramount, with an ever mounting institutional rise of mental incarceration

There must be some consideration, with the speed of living, the stress of contacts and stretch of imagination.

In these times, science must needs go in every direction at once; but there must be cohesion. Are our medical graduates prepared to go forth and take their place in this maelstrom? Are we a link in this closely integrated chain? Do we have our tentacles fastened deeply in the economics, philosophy, arts and history? Will the State wait? Should the focal point be graduate, or under graduate in Maryland; or the nation, for that matter? What is the right proportion?

Strong intellectual and moral leadership is essential. "In veniemus viam aut faciemus."

Prediction as to the outcome, is now limited to conjecture for the most part, but truly we will find a way. Never were there more thoughts on why and how this must come about, but there must be action. We are of age and we are the leadership. We are the leaders. We are looking over the horizon.

The West is no farther from the East, than once around the clock. Color, creed and philosophy, no longer have definitive boundaries. We and we alone, have that in our destiny.

Choose your sides! Mark your objectives. Give the command? March forward.

"I have loved no darkness,
Sophisticated no truth,
Nursed no delusion,
Allowed no fear.
—Sir William Osler

7 Washington Street
Cumberland, Maryland

Important Reminder

ENROLLMENT IN BLUE CROSS AND BLUE SHIELD

for

MEMBERS OF THE MEDICAL AND CHIRURGICAL FACULTY

November 1957

The annual Blue Cross and Blue Shield enrollment for you and your employees occurs in November. During this enrollment period, applications will be accepted for new memberships and for changes in present coverage. In October, before the enrollment period begins, you will receive application cards and full information on the enrollment. November is the only time that Maryland Medical Service, Inc., and Maryland Hospital Service, Inc., will accept applications for insurance in Blue Cross and Blue Shield. These applications must be in their office, 200 W. Baltimore Street, Baltimore 1, by NOVEMBER 20, 1957.

Scientific Papers

COMMISSUROTOMY IN MITRAL STENOSIS[1]

OTTO C. BRANTIGAN, M.D. AND CALVIN Y. HADIDIAN, M.D.[2]

The blind or closed surgical approach to the treatment of mitral stenosis is so well accepted by the medical profession that patients with the proper indications are advised without undue hesitation to submit to surgery. However, it is well to remember that prior to the last half decade intracardiac procedures of any sort belonged in the realm of experimental procedures and were frowned upon by a large section of the profession when applied to human beings. The work of Lillehei (1) and others undoubtedly has shown that the era of open heart or intracardiac surgery under direct vision is just beginning. It will not be long before the blind type of surgery will be abandoned.

History

Sir Lauder Brunton (2) in 1902 was the first to suggest the possibility of surgical treatment of mitral stenosis. Allen and Graham (3) in 1922 recorded their results in experiments on twenty-two dogs in which they introduced a cardioscope with attached light and blade through the left auricular appendage. In 1923 Culter and Levine (4) reported survival in one patient who underwent a "valvulotomy." The valvulotome was introduced through the left ventricle and incisions were made through the medial and lateral aspects of the valve. Although the patient survived the procedure, the benefits to him were dubious. Souttar (5) in 1925 inserted his finger through the appendage, felt the mitral orifice and found it to be insufficiently stenotic, to warrant any dilatation. Cutler and Beck (6) in 1929 summarized their experiences in ten patients with mitral stenosis. They used finger dilatation, incision of the valve by means of tenotome knives, and excision of a segment of the valve with the aid of a cardioscope-valvulotome combination. There were seven approaches through the ventricle and three through the auricle. At the time their report was made there were two living patients, both of whom had had finger dilatations. It is interesting to note that they postulated the theory that the problem of mitral stenosis could be solved by changing it into a regurgitant valve.

For some unknown reason there followed a period of almost two decades during which time there was little, if any, effort, experimental or clinical, to add to the already existing experiences in intracardiac surgery. The era of renewed interest started with the work of Bailey (7), Harken (8) and Smithy (9) in 1948 when they revived hopes of success for the surgical treatment of mitral stenosis. The principle of commissurotomy and the splitting of the diseased valve along its fused commissures became a well recognized and standardized procedure. The enormous strides made by the profession in this and other phases of intracardiac surgery for both congenital and acquired diseases during the last five or six years are well known. The morbidity and mortality following such procedures have been reduced to satisfactory levels, thus encouraging widespread usage of the procedure by most thoracic surgeons in the country.

Anatomic Considerations

Gray (10) describes the mitral valve as consisting of two triangular cusps, formed by

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duplications of the lining membrane, strengthened by fibrous tissue, and containing few muscular fibers. Their outer margins are attached to the fibrous left atrioventricular ring. Gray also explained the presence of two tiny cusps at each angle of the mitral orifice interposed between the larger anteromedial or aortic cusp and the smaller posterolateral one. The superior surface of each cusp is smooth whereas the inferior surface is rough and provides attachment to the numerous chorda tendineae from the papillary muscles.

There is one aspect of the anatomy of the mitral valve which unfortunately has received little attention in textbooks. This is the mode of attachment and the number of chorda tendineae in relation to the two major cusps (Fig. 1 and 2). The chorda tendineae attached to the anteromedial cusps are fewer in number and are grouped into two large bundles that attach themselves to each end of the under surface of the free border of the cusp. They traverse a long distance from their origin at the papillary muscles to their insertion (Fig. 3 and 4). Unlike the former, the chords of the posterolateral cusp are more numerous, shorter in length, and widely spread over the under surface of the free border of the corresponding cusp. The importance of this particular arrangement of the chorda tendineae will be apparent later in the course of this article.

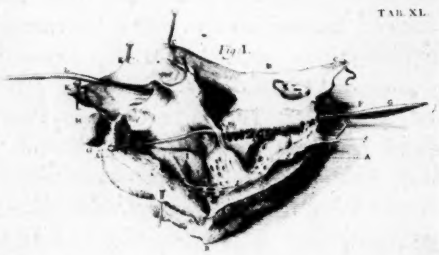

FIG. 1. A drawing taken from the work of William Cowper (16) done in 1724 in which can be seen the posterior mitral leaf with the numerous chorda tendineae. This arrangement has been found in approximately one-half of about 100 anatomic specimens studied. Such a valve assures little regurgitation if the posterior leaf is divided instead of the commissure. There would be little ill effect if one or more of the chorda tendineae were divided at surgery.

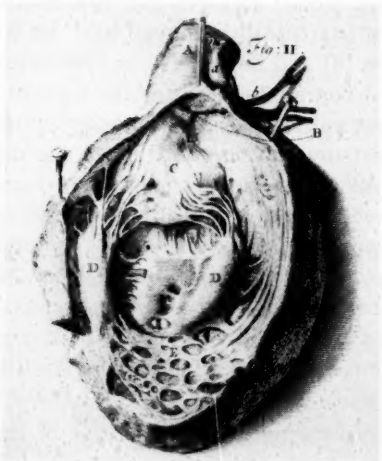

FIG. 2. A drawing taken from the work of William Cowper (16), 1724. The anterior leaf of the mitral valve showing it to be suspended from the side by chorda tendineae and papillary muscles. (Fig. 3) A cut through this valve or the chorda tendineae will result in definite regurgitation. This illustration shows how the valve acts as a baffle plate. (Fig. 4)

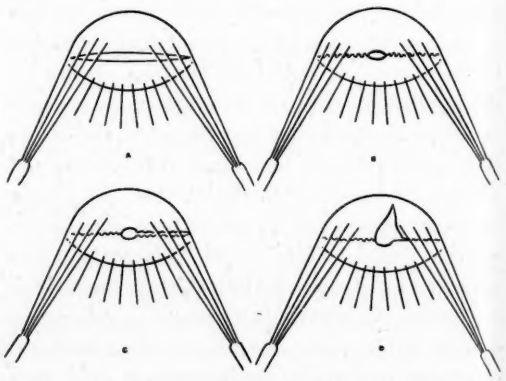

FIG. 3. (a) this arrangement of the chorda tendineae on the mitral valves has been found in about 50 per cent of the valves examined in the anatomic laboratory. It is a favorable arrangement and was illustrated by William Cowper (16) in 1724. (b) The method by which rheumatic fever brings about stenosis of the mitral valve. (c) The proper site of division of the stenotic valve. (d) The improper division of the anterior leaf, which also shows how pull from the papillary muscles separates the valve at the site of the cut. This would not occur if the posterior leaf were cut.

PATHOLOGIC AND CLINICAL CONSIDERATIONS

The gross and microscopic pathology of rheumatic carditis and specifically valvulitis are common knowledge and need not be repeated here. Whether or not stenosis or regurgitation will predominate in a specific case depends upon the type of involvement of the cusp, shrinkage, and contraction or dilatation of the atrioventricular ring. The pure mitral stenotic type has a smaller than normal atrioventricular or valvular ring and valves, without a definite contraction or loss of valve substance. The valves may be delicate or thickened. In either instance the effects of stenosis are the same but the results of surgery are likely to be different. In the types with both stenosis and regurgitation there is a loss of valve substance and/or a contracted deformity of the valve edge that is equivalent to a loss of substance, and there may be an atrioventricular or valve ring of variable size. The stenotic and regurgitating type may be the result of calcification of the ring that holds open an orifice through which blood regurgitates. It is almost the equivalent of a loss of valve substance. Both types with regurgitation tend to lessen the prospects of satisfactory surgical results. Many cases have a combination of stenosis and regurgitation; obviously those with pure stenosis offer the best prognosis from surgery. Since rheumatic fever produces a pancarditis, pathologic evidence of the disease often can be found in the myocardium in the form of typical Aschoff bodies. The presence of these findings in excised auricular appendages has led to considerable discussion as to their significance in relation to the activity of the disease. It is generally agreed by most pathologists and thoracic surgeons that the presence of microscopic evidence of rheumatic fever in the myocardium, which is said to occur in about 50 per cent of excised appendages, bears no definite relation to the activity of the carditis; nor does it in any way forecast possible reactivation of the disease after surgery.

The pathologic physiology of mitral stenosis is essentially one of increased pulmonary vascular pressure. The critical rise of this pressure on exertion is the basis for the dyspnea and the intermittent attacks of pulmonary edema that these patients experience. Andrus, Blalock, and Bing (11) reported that the failure of the pulmonary arterial pressure to return to normalcy after surgery suggests that there are important changes that increase resistance in the pulmonary vascular tree as a result of long standing engorgement. There is undoubtedly thickening of capillary walls and narrowing of capillary lumen. However, the gratifying results of surgery are shown in the absence of the critical rise of the intravascular pressure during exertion that usually leads to undesirable complications. The effects of the prolonged vascular hypertension in the lungs are not only seen in the blood vessels themselves, but also in the surrounding lung parenchyma in the form of low grade perivascular inflammatory processes which eventually lead to fibrosis and a firm and inelastic

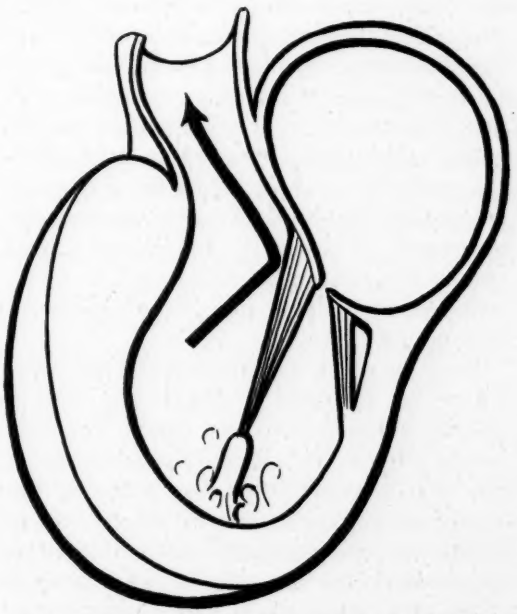

FIG. 4. This drawing shows how the anterior mitral leaf acts as a baffle plate for the aortic outflow tract.

lung. The effect of this change on the pulmonary function of alveocapillary gas exchange is obviously detrimental and reduces to a great extent the overall pulmonary function reserve of these individuals. These conditions are some of the basic factors in the plea for early surgical intervention in established cases of mitral stenosis.

The source of hemoptysis in this condition has been the subject of careful study and it is generally agreed that frank bloody expectoration is usually caused by the rupture of engorged bronchial veins (12). Rusty sputum, of course, is a sign of alveolar engorgement with blood cells and as a rule is the effect of the engorgement of the pulmonary arteriolar and capillary systems.

In order to better understand the results of surgery in the different stages of the disease, a form of classification of patients suffering from mitral stenosis was found to be imperative. The classification most commonly used is that of Harken (13) who places all patients in one of four clinical groups. Group I includes all patients who exhibit the signs of mitral stenosis but are free of subjective symptoms. Group II is referred to as the stage of subjective symptoms with little or no disability, or at least where the disability is not getting worse. Group III includes the patients in whom subjective symptoms, dyspnea, and limitations of activity are gradually progressive. In Group IV are classified a large number of patients who are known to be terminally incapacitated and who are often in irreversible cardiac failure.

From the above classifications and the observation of associated anatomic and clinical findings, surgeons have been able to formulate certain criteria that indicate the recommendation of surgery and others that should be considered as contraindications for surgery. Group I does not require surgery. Group II patients appear to be the best surgical risks, although Group III, the progressively incapacitating group of patients, is almost as good a risk. The patients in terminal Group IV are grave surgical risks; the operative mortality is high. The results of surgery in this last group are extremely good when there is a favorable outcome. Glover, et al. (14) placed the following conditions in the group of ideal indications: pure mitral stenosis, minimal left atrial and right ventricular enlargement, normal electrical axis or right ventricular strain, and early functional incapacity. Among the acceptable conditions they cite advanced dyspnea, reversible cardiac failure, associated mitral insufficiency in the presence of a normal left ventricle, auricular fibrillation with controllable ventricular response, progressive incapacitation, and arterial embolic episode and recurrent hemoptysis, the latter two sometimes necessitating emergency procedures. Included in the several definite contraindications are acute rheumatic fever, subacute bacterial endocarditis until controlled, and marked mitral insufficiency, especially with enlargement of all cardiac chambers.

Surgical Considerations

A detailed account of the surgical technic in mitral commissurotomy would be superfluous for present day readers, but it is necessary to stress some of the important aspects and pitfalls in this operative procedure. There is general agreement on the advisability of finger fracture of the valve before any attempts are made with the knife. The reasons for this are obvious when one considers the blind nature of this type of surgery and the dangers of cutting adjoining structures which one wishes to avoid. When finger fracture is used the split in the valve is usually made along the line of the commissures, whereas with a knife the likelihood of the cut being made in one or the other leaflets increases considerably. The risk of the knife blade hooking on the chorda tendineae and cutting them is not to be underrated. In this connection it becomes obvious that the safest error in such a case would be to cut through the posterior rather than the anterior chords. The reason for this, of

course, is the peculiar arrangement of the chorda tendineae with respect to the two leaflets. Since the anterior group is in two distinct bundles, any cut made through them will have serious effects on the competency of the mitral valve. Accidental tears through the posterior group will not hamper proper closure of the valve because only a few in a row of numerous chords are involved. It has been shown that many valves can be only partially fractured or torn with the finger and then a cut with the knife is indicated. It is generally agreed that a recurrence of stenosis is likely in the finger fracture type of operation if the fibrotic stenotic ring is not completely torn apart or if the tear is not carried all the way to the ventricular wall. It is also usually admitted that when the valve is adequately cut there is rarely, if ever, a recurrence of stenosis.

One aspect of the surgery of mitral stenosis is worth dwelling upon further since it continues to be at present one of the few remaining causes of concern to the surgeon. This is embolism during and immediately following surgery. These emboli can originate from the auricular appendage, the left atrial wall or from calcifications around the mitral orifice. Naturally, the most serious results are anticipated when they lodge in the brain. Bailey et al. (15) reported an incidence of 5.1 per cent of cerebral emboli with a 66 per cent mortality in the involved cases. They noticed a severe drop in systolic and diastolic pressures as the first sign, with a rapid return to normal. Efforts to prevent this dreaded complication have resulted in the use of several methods, including the flushing of the atrium and appendage by intermittently removing the clamp. In order to avoid going through a thrombosed left auricular appendage, the left superior pulmonary vein also has been used as a portal of entry. Probably the simplest method is the external occlusion of the carotids by the anesthetist during the manipulative period and for a few seconds thereafter. However, its effectiveness is rather questionable. Bailey reported the use of internal occlusion of the innominate and left common carotid arteries by means of bull dog clamps during the hazardous moments but this has not succeeded in eliminating the emboli. The authors have not used any preventive measures and have had two patients who suffered embolisms. One of these patients died as a result of the embolism.

Analysis of Material for Present Study

The present study is based on thirty-three patients who underwent mitral commissurotomy. These were done by the senior author or by the resident staff in various hospitals under his direct supervision. There were twenty females and thirteen males. The ages varied from eighteen to fifty-one years, with an average of thirty-six. There were no patients in Group I or Group II, twenty-six in Group III, and seven in Group IV. In twenty-six the type of pathology found at surgery was pure stenosis and in seven there was a varying amount of regurgitation. There were five hospital deaths. Two of the deaths occurred in the seven patients of Group IV and three of the deaths were among the twenty-six patients in Group III. In the three fatalities of Group III, one died of a technical error and one of systemic and pulmonary multiple emboli. At autopsy there were multiple new and old emboli in all heart chambers except the left auricle. One patient died of cardiac arrest on the operating table. Of the two deaths in Group IV, it was evident that the operation was much too strenuous for the patients. In the twenty-six patients with pure stenosis prior to operation, twenty-two showed no regurgitation after commissurotomy. In only three patients was there microscopic evidence of Aschoff bodies in the excised auricular appendages. The follow-up period has varied from six months to three and one-half years. The results were arbitrarily classified as good, fair, and poor, judged from the functional state of the patient after leaving the hospital. There were twenty-two patients

with good results, four were fair, and only seven showed poor results or died.

Discussion

It is obvious that certain features of the patient and the pathology of mitral stenosis influence the operative mortality and the end result. It is also apparent that the operative technic is extremely important with regard to the end result and the operative mortality.

The presence of active rheumatic fever is almost certain to bring about a poor result. Obviously, such a patient will not knowingly be subjected to operation. If there is a flare-up of the disease in the postoperative period death may result from cardiac failure or there may be thickening of the formerly thin valve which would make it a less satisfactorily functioning valve. It is evident that the disease can cause the divided valve to undergo a recurrent stenosis. One patient, aged thirty-two, not included in the series because she had recently undergone surgery, was found to have a delicate valve at operation; however, the orifice was eccentrically placed, being adjacent to the lateral ventricular wall. The valve was divided in the anteromedial direction sufficiently to provide about a two finger opening. There was a slight regurgitation at the completion of the operation. The left auricular pressures dropped from 54 cm. to 24 cm. of water on the operating table. The patient experienced a period of low blood pressure after surgery, but recovered. Subsequently she was able to be out of doors and seemed to be greatly improved. However, she developed a low grade fever and progressive difficulty and died three months after surgery in cardiac failure. At autopsy the opening in the valve would not admit one finger and the whole valve was considerably thickened, at least four times thicker than at the time of operation. There was definite pericarditis, undoubtedly rheumatic in nature. Of course, such a condition had led many workers to believe that antirheumatic antibiotic therapy should be administered to all mitral stenosis patients for at least four to six months postoperatively.

The condition of the heart influences the mortality to a great degree. In Group IV the mortality rate is likely to be high since the heart can withstand little surgical trauma. Therefore, cardiac hypertrophy and muscular damage by overstrain of the disease constitute a real handicap. These patients probably will respond satisfactorily if an adequate valve opening can be obtained and if the patients survive operation. The heart has a wonderful power of recovery. Aside from a high operative mortality rate this is the best group to treat. The patients in Group IV are those who have the real symptoms and incapacitation. Relief of symptoms is deeply appreciated by the patients. The authors have not had experience with Groups I or II where obviously the patient cannot experience as dramatic benefit from the operation as in the other groups since there is not the same degree of incapacitating symptoms.

Conditions of the valve also influence the outcome. If there is loss of substance there usually will be regurgitation after operation. When the valve is greatly thickened the operation will prove to be technically difficult. If the valve opening is eccentrically placed against the posterolateral ventricular wall, it will be difficult to open it properly. Where the chorda tendineae obviously are misplaced and in a disadvantageous site, regurgitation is more likely to result from inadvertently cutting one or more of them. All these factors influence the immediate operative mortality and the end result achieved by the patient.

From a technical aspect, the easier the operative procedure the lower will be the mortality rate. If the valve is divided in the correct site and the opening made adequate, the end result will be excellent barring unpredictable complications common to all surgery. However, as it is carried out at present the surgery is blind, that is, it is done without the benefit of direct vision. It is actually done without finger guidance so far

as the knife blade is concerned. One can palpate before and after the cut. If the valve is adequately opened with finger dilatation or by fracture the operative mortality will be low, since there is little danger of regurgitation and it is quickly accomplished. However, if the valve opening is not of adequate size, little permanent help will be obtained. Recurrence of the stenosis is both possible and likely.

It is obvious that if the surgeon could have thirty seconds in which to work under direct vision he could make the valve opening in the correct site, of adequate size, and actually of normal diameter. It is predicted that eventually all cardiac surgery will be done by the open heart method under direct vision when the technic of open heart surgery becomes safer.

Conclusions

The anatomy of the mitral valve and its significance during the surgical procedure are discussed. The pathology of the stenotic mitral valve is explained and its relationship to the results of surgery emphasized.

The authors' experience with thirty-three patients is summarized and the figures analyzed.

It is predicted that in the future all cardiac valve surgery will be carried out by the open heart method under direct vision.

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CYTOLOGIC SERVICE, AMERICAN CANCER SOCIETY

HOWARD W. JONES, JR., M.D.*

I am very glad to accept the invitation of Dr. George Yeager to record some of the details of the efforts of the American Cancer Society to help to provide facilities for cytologic service for physicians in the State of Maryland.

In 1947, the Cancer Society made a survey of cytologic facilities in the State and found that at that time there were very few physicians in private practice, and no hospitals or other laboratories which accepted cytologic material. Because of this deficiency a cytologic laboratory was started in the Department of Health of the State of Maryland. This laboratory was initially financed by a grant from the American Cancer Society, Maryland Division, Inc., and from the Federal Government, but within a few years it was taken over entirely by the State Health Department. The purpose of this laboratory was to furnish facilities for cytologic examination to augment the growing private facilities available and to furnish cytologic facilities for public clinics and indigent patients. It was anticipated that this operation would be of limited scope.

In the decade since the laboratory was established, the demands for the facilities and the number of specimens submitted to the State Health Department have increased annually, so that by the end of 1956 specimens were being received at an annual rate of about 30,000 per year. In 1954, 1955, and 1956, a special Committee from the Cancer Society, the Maryland Society of Pathologists, and the Maryland Obstetrical and Gynecological Society, studied the problem of cytologic examination facilities. There was reason to believe that the number of private facilities available for handling this material would increase but it became increasingly apparent that one of the greatest problems was the inability to secure trained cyto-technicians. The American Cancer Society, Maryland Division, Inc. provided traineeships for technicians in the years 1955–56 and 1956–57, but the number of applicants, who would necessarily have had to train out of town, was limited. Meanwhile, the load on the Health Department became so great that on December 3, 1956 it was necessary to close the Cytology Division of the State Health Department Laboratory to new specimens because it was impossible to keep abreast of the specimens being received, and approximately 10,000 unexamined smears had accumulated in the laboratory.

In order to attempt to provide facilities for training cyto-technicians within the state, and to provide post-graduate facilities for instruction of physicians in cytologic technique, the Cancer Society during this past year appropriated approximately $50,000 for the establishment of a new laboratory in each of the two Medical Schools. The purposes of these two laboratories were to be—

1) To provide training for cyto-technicians.
2) To provide courses of instruction for physicians in cytology.
3) To provide additional service facilities for the institutions where the laboratories were established and to accept specimens sent in from the outside.

Dr. John K. Frost, a Pathologist experienced in cyto-pathology, was obtained to direct this effort. Two laboratories were established in November 1956, one at each of the two Medical Schools. The first course for medical technicians in Exfoliative Cytology, was held at the University of Maryland School of Medicine from January to June 1957. Six cyto-technicians were certified upon completing their training. The second cyto-technicians course will be held in the Fall of 1957 at the Johns Hopkins University School of Medicine. A weekly seminar for

* Medical Director, American Cancer Society, Maryland Division, Inc.

resident physicians conducted in the Spring of 1957 at the Johns Hopkins Hospital, will be continued this Fall at the University of Maryland Hospital. In addition, two courses for practicing physicians are being planned for the Winter of 1957–58 on the latest advances in the use of Exfoliative Cytology—one for pathologists and one for clinicians. The primary training responsibility of these laboratories thus has been such, that the number of specimens they have been able to process has been limited. It is thought, however, that the ultimate solution of the problem of adequate cytologic facilities lies in the training of additional personnel, and from a long range point of view adequate and wide spread cytologic services will be available by the personnel trained in these two laboratories when they are integrated into existing private and hospital laboratories.

It should be mentioned that the two medical school laboratories are not supported entirely by the Cancer Society, but derive a substantial part of their support from grants from the Federal Government through the National Institute of Health, from fees received for processing specimens, and from the two institutions housing the laboratories. Meanwhile, the laboratory at the State Health Department has worked through its backlog and on June 25, 1957, the Health Department was able to announce that its laboratory was again receiving specimens. Their facilities have not been increased and it is of course obvious that it will be necessary for physicians to make use of the services of private laboratories in order to provide widespread use of this important diagnostic technique.

Although, historically, the cytologic examination for cancer was originally applied to the female genital tract, it is to be emphasized that it is applicable to many other areas; the gastrointestinal tract, the urinary tract and the respiratory tract, representing the areas which have been most intensively studied. The training given by Dr. Frost and his associates covers all of these fields. It is difficult, of course, to estimate the demand which will be made for facilities of this kind. However, if one may use the number of specimens received by the State Health Department Laboratory as a guide to the future, a plateau has not yet been reached in the demand for cytologic facilities.

While it will doubtless be a year or two before sufficient trained personnel are available to service all areas of demand, great strides have been made. A few technicians were previously trained out of the state under American Cancer Society subsidy and are now working at Easton Memorial Hospital, at Womens Hospital, and at Mercy Hospital. Of the six technicians recently trained and certified, one is at Union Memorial Hospital, one at Maryland General Hospital, one is doing pulmonary research, and three have remained with Dr. Frost at his training and service laboratories. All of these laboratories are now able to handle a much larger service volume and will help to provide private service until those facilities become completely adequate. With the Health Department Laboratory continuing to furnish cytologic facilities and private facilities increasing at their present rate, it appears that under the plan that has been adopted adequate facilities and personnel will be available in due time.

20 East Eager Street
Baltimore 2, Maryland

THE MEDICAL AND LEGAL PROBLEMS OF TRAFFIC ACCIDENT PREVENTION[1]

PANEL DISCUSSION[2]

MODERATOR: HONORABLE JOSEPH R. BYRNES

PANEL MEMBERS: HOWARD F. KINNAMON, M.D.
MANFRED S. GUTTMACHER, M.D.
L. W. FARINHOLT, JR., ESQ.

DR. RUSSELL S. FISHER, *Presiding*

DR. FISHER: As the Chairman of the medical part of this Joint Symposium, it is my privilege to speak for the Medical and Chirurgical Faculty, to welcome you here this evening, and to explain briefly the background of this symposium and others like it.

During the past five years, in an effort to clear the medico-legal problems that sometimes arise between the two professions of medicine and law, there has been functioning a joint committee of the Bar Society and the Medical Society, to use the colloquial terms.

This is the fifteenth symposium of the two societies on medical and legal subjects sponsored by this committee. I need not tell you what the previous ones have been. Many of you have been here. I am personally convinced that they have done a great deal to clear some of the misunderstandings and to help, if you will, lay down the ground rules of our joint professional activities.

The subject of the symposium tonight is "The Medical and Legal Problems of Traffic Accident Prevention." I won't do more in announcing this subject than to tell you that the Moderator of the evening is the Honorable Judge Joseph R. Byrnes, of the Supreme Bench of Baltimore City.

Since he will not have a chance to speak for himself, I would like to take the liberty of telling you a little bit about Judge Byrnes.

He was born in this city in 1900. He will have a birthday very shortly. He attended Loyola College and was graduated from the University of Baltimore Law School in 1931.

He had a very lengthy and interesting experience, as a member of the Legislature between 1943 and 1950, being President of the Senate for the last three years of that time.

He then moved to the Supreme Bench. He was appointed Dec. 8, 1950, and was elected to the fifteen-year term in Nov. 1952.

He has been a presiding judge since that time; in addition he has served on many boards and committees. He was Secretary to the Judicial Conference of Maryland for a three-year period. He is at the present time a member of the Commission for the further study of the Judicial System.

He is an eminent and capable jurist and one honored by all.

And so I am very proud to introduce to you your Moderator, the Honorable Joseph R. Byrnes.

700 Fleet Street
Baltimore 2, Maryland

[1] Presented at the One Hundred Fifty-Ninth Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland on Wednesday, May 1, 1957, in Osler Hall, 1211 Cathedral Street, Baltimore 1, Maryland.

[2] Arranged by the Joint Committee on Medicolegal Problems, of which Mr. John S. Stanley is the Chairman for the Maryland and Baltimore City Bar Association, and Dr. Russell S. Fisher is the Chairman for the Medical and Chirurgical Faculty.

INTRODUCTORY REMARKS

HONORABLE JOSEPH R. BYRNES, *Moderator**

JUDGE BYRNES: Thank you very much, Dr. Fisher.

I think I am fortunate, ladies and gentlemen, in having Dr. Fisher introduce me tonight rather than some other doctor whom I met in the past year. I am not sure that the introduction in that case would have been as courteous and as generous as the introduction Dr. Fisher has given me tonight.

And I should like to say at the very outset that I am very happy and privileged to participate on this panel.

My task is both pleasant and simple. It is pleasant because it is my privilege to present for your edification and information three distinguished people, all well versed in their own fields. I am sure what they will have to say will be of great interest and profit to all of us. It is simple, in that Dr. Fisher has already given us the topic. I think its mere recital: "The Prevention of Accidents and the Legal and Medical Problems Attendant Thereto" is in itself a sufficient indication of the importance of the subject.

And so there is no need for my telling you just how important the subject is. I think we all are aware of it.

But I do believe that there has been too much apathy on the part of the public in recent years toward the tremendous increase in automobile accidents and the results that have attended them.

It is comforting to know that some of that apathy is disappearing. I think this meeting tonight is an indication of that. And I am hopeful that there will be some bold suggestions made here tonight, almost revolutionary, because I think it is going to require bold and revolutionary suggestions to completely awaken the public to the great need for remedial steps in the direction of a lessening of the accident and fatality rate.

Some evidence of public awareness in this problem is evidenced by a recent article published in the press by Mr. Charles S. Rhyne, known to many of us, or at least the lawyers, as a very active member of the American Bar Association, when he addressed a subcommittee of the House of Representatives on the question of remedial legislation directed toward reducing the accident rate of automobiles. In his appeal to the Committee, he characterized the situation in very strong language when he said that the American driving public is "guilty of unpremeditated savagery."

Now, that is certainly a strong expression from one who ordinarily does not deal in extreme language.

I read an article recently by a doctor who gave a talk in a medical symposium similar to ours in which he referred to the fatality and injury rate in automobile accidents as "a blot on our national reputation."

So we can see, ladies and gentlemen, when people of that standing express themselves so forcefully, something must be done. And it is but fitting that the members of the City and State Bar Associations and the medical profession should assume the leadership in trying to do something about it. The community, I think has a right to look to the lawyers and to the medical profession to undertake that leadership.

So I think it is a very happy occasion that we are assembled here tonight, and I am sure that it is not in my province to give any personal ideas of my own, and I will not usurp the time of the speakers, but perhaps you will permit me to make one slight observation.

We have present in the audience a member of

* Judge, Supreme Bench of Baltimore City.

the Maryland Legislature, who was chairman of a Committee of the Legislative Council which framed a number of bills in an effort to correct some of the conditions that we know exist. I am referring to Mr. Edgar Silver. He personally did a very fine job, but unfortunately many of his Committee's recommendations were not approved by the Legislature. They failed of passage because of public apathy, and I think that some of that apathy might be attributed to the press.

I find myself annoyed sometimes when I read the editorials in the Sun. This paper seems to take the position that speed is the prime killer, so why bother about lesser factors. The Sun strenuously opposes annual inspection of vehicles, and looks with some disfavor on periodic physical examination of drivers.

I do not think that the recommendations that Mr. Silver has made to the Legislature are in themselves a panacea or cure-all, but if enacted into law they would be a step in the right direction.

Take, for example, the defective automobile. I think it is a real menace. Five per cent, if not more, of automobile fatalities are attributed to these vehicles.

I recall a case not too long ago in my court, where a lady passenger was pregnant, with the baby due in one month. Her husband took her out for a drive, with two or three children, and when they were crossing the intersection of Preston and Caroline Streets, a driver of another automobile came into the intersection, in violation of the Boulevard law, and the two automobiles collided. The lady was thrown out of the automobile and died a few hours later. The other car was driven by a soldier from Aberdeen, who was drunk. In addition, the car had practically no brakes. Police showed pictures of the brakes on the car. And I think but one wheel had brakes, and those were in bad condition.

Of course, those cases are extreme, but I don't believe there is a person present here tonight who would object to the inconvenience of going to the Automobile Commissioner's Office to have his car inspected if he knew that by so doing, he might be saving the life of just one person.

The public must be made aware of the fact that they have to sacrifice some of their convenience for the good of all; and when that is done they will accept the inconvenience in better fashion.

Now, it is true that speed is a factor, and defective brakes are also a factor, but it is also true that the human equation is a most responsible agent in auto accidents.

We in Baltimore City know, of course, that although speed is very often a factor, we also know that frequently drivers fail to stop for boulevards and intersections marked with "Stop" signs.

And so I think it is well tonight that a good deal of our panel discussion will center about that particular phase.

We are extremely fortunate to have these experts—and I am sure they don't want to be called experts, because of their modesty—but they are men who are familiar with this topic that we have before us, and I am sure that what they will say will be of interest to all of us.

Now, to begin our program, we are fortunate to have a very fine physician from Easton, Dr. Howard F. Kinnamon, who has taken the time and trouble to come up here tonight to participate in this discussion. And I am sure that his efforts will be very well received. He will speak on the medical and surgical problems of motor vehicle accident prevention.

Dr. Kinnamon is a graduate of the University of Maryland and the New York University Undergraduate School. He graduated from the University of Maryland Medical School in 1939. And for four years he was resident surgeon at the Mercy Hospital in Baltimore. He served four years in the Army. He has practiced orthopedics and traumatic surgery at the Memorial Hospital, in Easton, for the past eleven years.

He is a member of a number of distinguished societies, and is a consultant in orthopedics at the Eastern Shore Hospital.

It is my pleasure to introduce Dr. Kinnamon, and I am sure it will be your privilege and pleasure to hear him.

Court House
Baltimore, Maryland

THE MEDICAL AND SURGICAL ASPECTS

HOWARD F. KINNAMON, M.D., F.A.C.S.*

JUDGE BYRNES, ladies and gentlemen:

I suspect that some of you wonder how you could get an Eastern Shore man up here. Well, it was not easy.

Most doctors are not used to talking. We are accustomed to listening. And so it is doubly difficult for a doctor to stand talking to a number of people. One may be all right, but a number is difficult.

Now, why am I interested in this subject?

Well, we see it at first hand on the Eastern Shore. We are on State Highway Route 50. And we see at first hand automobile accident victims when they are brought in. We do not have a house physician in our hospital, and so we personally see the accident cases when they are brought in.

I had the unpleasant duty of watching a sixteen year old child, a daughter of a very good friend of mine, die last year. She was injured when her sixteen-or-seventeen-year-old friend and owner of a Juggernaut capsized. They were not able to quite make a hundred and ten on the turn. The boy had been drinking.

That is one of many problems. We see them frequently. We are concerned about them. We feel that we should do something about them.

The medical and surgical problems of motor vehicle accident prevention is something that I could go into, but I am not going to bring up any references about them, because it would take too long.

The medical profession is responsible for treating the victims of automobile accidents. Almost forty thousand people are killed and another two million injured per year. We must assume a greater responsibility for the prevention of these accidents.

There are a number of factors which must be considered and individually evaluated.

I will enumerate them.

First, the requirements for licensing motor vehicle drivers.

Second, the control and re-examination and possible removal of drivers who have become dangerous due to disease or injury, and those whose licenses have been suspended or revoked.

Third, the study of the mechanics of direct injuries to drivers and passengers, such as that of the Cornell Study.

Fourth, the drinking driver.

Fifth, the problem of the teen-age driver.

Sixth, the repeater or the accident-prone driver.

I have tried to confine my thoughts to medical and surgical problems rather than legal or otherwise.

First is the question of requirements for the licensing of motor vehicle drivers.

In Maryland, to reacquaint you with the regulations, there are in the driver application form only three questions concerning the medical history of the applicant.

Number one, and I quote, "Have you ever been treated for fainting or dizzy spells, epilepsy, heart trouble or paralysis?"

Number two, "Have you ever had any mental or physical incapacities or infirmity?"

* Member Medical Advisory Board, Department of Motor Vehicles of Maryland.

Number three, "Are you crippled in any manner?"

That is the entire history. It is quite inadequate.

We as physicians know that certain physical and mental conditions make such drivers dangerous.

At present we have very few means of preventing incapable drivers from acquiring licenses.

In Maryland, in 1956, there were 152,950 instruction permits given. This is a formidable number as far as further examinations are concerned.

It is recommended that an improved drivers selection program be initiated. This would entail a complete history, physical examination, and whatever tests deemed necessary by the family physician and recorded on appropriate forms. The fees for such examination would be the responsibility of the applicant.

The family physician would be in an excellent position to know of epilepsy, diabetes, mental difficulties, and any disabling condition. If the physician will keep in mind that immature teenagers or epileptics and handicapped individuals will be driving on the same roads as he or his family and friends, he will tend to carefully scrutinize all potential drivers. If the physician feels that he does not care to pass on the applicant because of close association, friendship, or other ethical reasons, this applicant could be referred to the Medical Advisory Board of the Motor Vehicles Commission for action.

The second aspect that I mentioned, also handled by physicians, is the re-examination of drivers for cause, or as mentioned above, those who have had their licenses suspended or revoked.

At the present time the Department of Motor Vehicles cannot definitely state the number of drivers there are in Maryland. At the recent session of the Legislature there was legislation passed that was called a reregistration regulation of all drivers. This is to be done next year.

Drivers for cause should be re-examined by the Medical Advisory Board. This re-examination should involve all drivers with medical or physical disabilities that are obvious to the arresting or investigating officers, and all persons whose licenses have been suspended or revoked. This also was made into law at the last session of the Legislature, and it means that the Medical Advisory Board will have referred to it a large number of individuals.

I have spoken of the Medical Advisory Board of the Motor Vehicles Commission. I am sure that many of you do not know about it. This Board was first formed in 1947 by Dr. Howard Bubert and Commissioner of Motor Vehicles Elgin. At that time Dr. Bubert was medical advisor to the Commissioner of Motor Vehicles, and also to the State Police. He is now medical director of the State Police. He had many cases referred to him for evaluation by the Commissioner. These two men decided that a Board should be formed to carry out the function of review.

The Board is made up of physicians and surgeons, the majority being in the specialties. They are appointed by the Medical and Chirurgical Faculty. The purpose of the Board is to examine individuals referred to it and advise the Commissioner of Motor Vehicles of its findings and recommendations.

There are three sources of referral:

First, the applicant for a learner's permit who has affirmatively checked one of the three medical questions noted previously.

Second, individual drivers with acquired diseases or disabilities established by investigating officers or referred by physicians, friends, neighbors, or families.

Third, all persons whose licenses have been suspended or revoked.

In the ten-year period that the Board has been functioning, it has met 108 times and has examined or discussed 646 individuals.

As Dr. Bubert states in his report, the Board was something entirely new, one of the first of its

kind in the country, and the members slowly felt their way along.

In the first year (1947) there were 16 meetings, and 45 people were examined.

In 1956, there were 13 meetings and 156 people were seen and discussed.

In 1956 156 people were examined.

Of the 646 individuals examined, the majority were epileptics. Of 240 epileptics seen, forty-eight were given licenses on the first visit. Forty-seven were re-examined one or more times.

The second largest group, of whom there were 71, were mental patients. Thirty-two were given licenses on their first visit and eleven were re-examined.

The third group comprised 57 neurological patients. Twenty-six were recommended for license on the first visit and four have been re-examined.

The fourth group were medical patients, such as cardiacs and luetics. Fifty-four were seen; 34 were granted licenses, and 12 were re-examined.

The fifth group consisted of thirty orthopedic and traumatic cases. Twenty-three were granted licenses. This group included fourteen permits for hand-operated vehicles. These were mostly veterans. There have been fourteen diabetics and eight alcoholics. Of the entire group of patients referred to the Medical Advisory Board there were twelve without medical reasons for their difficulties. These were referred back to the Commissioner for disciplinary action.

The Board has no definite regulations regarding various medical conditions. Each person examined is an individual problem and is so treated.

In questionable cases the family physicians are contacted. Hospital records are obtained, and the reports of laboratory tests and consultations are used to determine the qualifications of the driver. If the patient is interviewed and he has no recent report or examination, he is referred to his physician for an examination and report.

The Board has recommended, because of the difficulty with epileptics, that epilepsy be made a reportable disease. Orthopedic and traumatic cases have offered very few problems.

We have two psychiatrists on the Medical Advisory Board. With the reports that we receive and the reports from hospitals and the psychiatrist's opinion, we can usually reach a satisfactory conclusion on mental patients.

Neurological problems, such as multiple sclerosis, have been most difficult, because of the possibility of progressive disease. Several patients with multiple sclerosis have been given a license, but with re-observation on a six-month or yearly basis. Licenses have been rescinded because of incapacitating progression.

In December 1956 the Board met with the Deputy Commissioner of Motor vehicles and Dr. Isadore Turck, Superintendent of the Spring Grove State Hospital, to discuss alcoholics as drivers. We questioned how the Board could meet requirements for taking care of alcoholics as an illness rather than as a legal problem.

It was Dr. Turck's opinion that if available records indicated that the individual was unable to control his drinking as evidenced by driving a motor vehicle while under the influence of alcohol or if he otherwise manifested his inability to stop drinking to excess, the Board was justified in assuming jurisdiction as in other cases assigned to it.

Since that meeting we have seen a number of alcoholics. Their number will probably increase. We hope in this manner to remove some of the alcoholics from the road.

Of the 646 individuals seen, we have records of only two being involved in motor vehicle accidents in a ten-year period. That is quite good.

The third basic factor to be considered is that of injuries. Doctors have been cooperating with the Cornell Study in reporting the types of injuries that have been occurring in automobile accidents, such as head injuries, fractures, concussion, and evidence of drinking. This type of study has been done in a number of locations throughout the county, as well as in Maryland.

These reports have been compiled and the results have been transmitted to the automobile manufacturers, with the effect of improved safety factors being installed on cars.

The Ford Automobile Company has come forward with the majority of added safety measures. However, all the manufacturers have added some features. It has been recommended that these safety measures be continued and expanded.

Eighteen per cent of automobile fatalities have been caused by drivers who were drinking. It is the hope of the Medical Advisory Board to eliminate some of them. The number of convictions of drunken drivers can be increased if blood or breath alcohol tests are used.

These tests have been proven to be accurate in the determination of the amount of alcohol in the patient's blood stream at the time of the test.

It was demonstrated at a meeting of the Legal Committee of the American Medical Association, that these tests could be used effectively in court if adopted into laws.

Dr. Heise, of Minneapolis, a recognized expert in the field of pathology and hematology who has devised methods of alcohol determination in the blood, was present for discussion at that meeting. He was also an expert witness at a mock trial.

In the trial an excellent demonstration was given of the means of convicting drunken drivers when the blood alcohol content, as determined by Dr. Heise's apparatus, was over 1500 milligrams per cent in the blood stream.

It is recommended that the Medical and Chirurgical Faculty actively back the use of these tests and bring about the necessary legislation for their enactment into law.

I am convinced from what I have seen that the teen-age driver is the one who is least capable of driving an automobile safely.

I have studied as many reports as I could find. I have some from the Maryland State Police. I have some from a number of other states. They are most confusing. One report that was most enlightening was the study at the University of Iowa of drivers in that State, on the basis of 100,000 miles of travel. It was found that in the 16-to-21-year group the accident rate was 1.5; the 22-to-27-year group was 1 per cent; and the 28-to-47-year group was $\frac{7}{10}$th per cent.

The Maryland State Police on the highway from Baltimore to Bel Air ran a test. The figures are not conclusive. However, they point to the young age group as being involved in more accidents.

I have talked to members of the State Police. We are now in the process of developing additional tests and obtaining more statistics on our State teen-age drivers. If this turns out the way I think it will, there will be a recommendation that the driving age, the age that the individual can start to drive, will be raised from sixteen upward.

It is recommended that this research be continued and expanded. It is also recommended that the school driving program be continued.

In conclusion, it is my firm belief that if all the agencies interested in this State, from the Governor on down, will lend their efforts on a Statewide basis there will be a marked reduction in the accident rate on our highways.

6 Glenwood Avenue
Easton, Maryland

JUDGE BYRNES: Thank you very much, Dr. Kinnamon.

We will hear from Dr. Kinnamon later. It is the hope of the Committee that we will have a very interesting question-and-answer period at the conclusion of the last speaker's address. For that reason each speaker should limit his remarks to twenty minutes. The written questions will be collected and brought up to the desk, to be given to the speaker to whom the question is directed.

It has been said that more continuous attention is required of the driver of a motor vehicle, at the moment, that is, than any other operator of public transportation. Some have estimated

that the driver of a motor vehicle has to make from twenty to thirty decisions in a half-hour; in the city, perhaps more.

It is particularly pertinent, therefore, that we should have Dr. Manfred Guttmacher, an outstanding psychiatrist, participate in this panel.

As the speakers are limited by their own suggestion to twenty minutes, I think it would be unfair of me to give a biographical sketch that I have of Dr. Guttmacher, because its recital would consume at least ten of those twenty minutes. However, I should like to briefly refer to his background.

Dr. Guttmacher graduated from Johns Hopkins University in 1919, and the Johns Hopkins Medical School in 1923. He has studied abroad. He was in the Army as a lieutenant-colonel in World War II, in charge of the Army's thirty-five mental hygiene clinics in the basic training camps.

He has been awarded the Legion of Merit.

He is currently the chief medical officer of the Supreme Bench of Baltimore City, which position he has held since 1930. I should tell you about Dr. Guttmacher's expert knowledge in his field and his unfailing help as chief medical advisor of the Supreme Bench. We just do not see how we could get along without him.

Dr. Guttmacher is a former president of the Maryland Mental Hygiene Society. He is a member of the Board of the Legal Aid Bureau, the Advisory Committee of the American Law Institute on model criminal code, and the Medical Coordinating Board, Seton Institute. He is psychiatrist to Johns Hopkins Hospital and several other local hospitals. He is also an associate professor of psychiatry, at the University of Maryland.

He has written "Psychiatry and the Law;" a biographical study of George the Third, "America's Last King;" and "Sex Offenses."

I am sure, Doctor, there is no connection between "America's Last King" and the last book mentioned.

It is particularly timely that we should have an expert to discuss with us the psychological and psychiatric aspects of accident prevention.

It is my pleasure to present Dr. Manfred S. Guttmacher.

PSYCHOLOGICAL ASPECTS

MANFRED S. GUTTMACHER, M.D.*

JUDGE BYRNES, and my friends, it is very good to hear oneself talked about in such flattering terms, particularly since Judge Byrnes is one of my thirteen judicial bosses.

I have been introduced as an expert, and I think that is somewhat unfair. I am no more an expert on this subject than anyone who drives. Everyone who drives considers himself an expert in regard to this problem.

I have, however, devoted some time to this topic, since I was given the assignment to go through the psychological literature and to try to cull out some facts.

* Medical Officer, Supreme Bench, Baltimore City.

I think it was Sydney Smith, the Eighteenth Century publicist, who said that figures don't lie but liars figure.

I will give you some of the figures that impressed me and let you draw some of your own conclusions from them.

From what I have been able to gather, in over 90 per cent of fatal accidents the cars involved were in good mechanical condition. And in a large number of those in which there were significant mechanical defects, the human factor was paramount, because it was the heedless individual who ignored the defects.

Excessive speed has been estimated to be a

prominent factor in 40 to 45 per cent of the fatal accidents. During 1955, in the twenty reporting states, 22 per cent of the drivers involved in fatal accidents had been drinking and 25 per cent of the adult pedestrians killed by automobiles had been drinking. In an analysis of over 600 automobile fatalities occurring during the 1955 Christmas holidays, 55 per cent were drinking drivers.

Now, what about the role of physical defects in the victims?

According to figures, which I believe are accurate, 7 per cent of the pedestrians in fatal accidents had physical maladies or defects which may have played a role in the production of the accidents.

In regard to the question of age, 11 per cent of the pedestrians killed were under fifteen, and 15 per cent of the pedestrians killed were over sixty-five.

Now, how about the age of the drivers?

With reference to those involved in fatal accidents, 4 per cent were drivers under eighteen. Of the drivers in fatal accidents, 8 per cent were eighteen-to-twenty, and 15 per cent were twenty-one-to-twenty-four, years of age.

The aged also present a driving hazard. Six per cent of the drivers in fatal accidents were over sixty-five.

Of course, the significance of such percentages depends on the number of miles driven. When a correction is made for this, the fact emerges that the 16-to-20-year-old youths are the ones involved in a disproportionately large number of fatal automobile accidents. The number of miles driven annually must be a factor in all such statistics. A woman driving three thousand miles a year would have to drive twenty-three years to equal the miles driven by the average operator of a commercial vehicle in a single year. And one has to hold this factor in mind when one hears glib generalizations about various groups of drivers.

In regard to the question of youth, Dr. Tillman, a psychiatrist, has written on this subject. He emphasizes the fact that youth is unwilling to accept responsibility. This is a normal characteristic of youth; and it also marks the abnormally immature adult.

Youth is eager to lead and flouts discipline and restrictions. It craves for excitement and cannot tolerate monotony. Recognition is gained through recklessness. Youth is strikingly egocentric—the rights of others get scant attention. Maturation brings new attitudes and new controls. And of course, as in every other skill, experience automatically increases efficiency.

An extensive series of special psychological tests have been devised to measure the psychophysical make-up of the driver, including distance judgment, visual acuity, night-sight vision, steadiness, reaction time, and a host of others. It is noteworthy that the youthful driver is the one who acquits himself best on such tests and yet he has the poorest driving record.

Dr. Alan Canty, the able psychologist who directs the Detroit Traffic Clinic, has found that marked impairment in judgment of speed and distance is generally found only in organic conditions.

We have heard much in recent years about "accident proneness" in regard to industry and automobile driving. This term was, I believe, first used by Greenwood and Wood in their analysis of the accident records of munition workers in England during World War I.

According to Drs. Flanders Dunbar, Karl Menninger and others, there exist individuals who have a reckless disregard of their own welfare, in some cases amounting to a real urge toward self-destruction. In some instances this is motivated by a deep unconscious feeling of guilt, which demands atonement through self-punishment. Recent statistical studies by psychologists tend to discount its significance. Dr. Frederick L. McGuire, an active contributor to the scientific study of traffic accidents, is of the opinion that not more than three or four per cent of traffic accidents are caused by repeaters

It has also been shown that individuals may have a series of accidents—apparently temporary accident proneness during a brief period, and then be accident-free for years.

Now, let us consider the role of mental disease in our problem. About this there are few reliable statistics. Since 1938 the City of Detroit has maintained, as a branch of their Court Psychiatric Service, a Traffic Clinic, staffed by psychologists and psychiatrists, to which great numbers of problem drivers are annually referred.

In the 812 cases examined in 1953 the following diagnoses were established.

I won't read through the whole list, but I will mention some important ones.

Eleven were considered mentally defective.

Only 2 per cent were actually insane or psychotic.

Two and eight tenths per cent had organic brain disease, and 2.2 per cent had epilepsy.

One per cent had senile deterioration, and 2.3 per cent had chronic alcoholism.

Twenty-nine per cent had an abnormal personality make-up. We shall talk about them later. These are personality deviates, but they are individuals who are not really suffering from any actual mental disease. In this group of 812 referrals there were only 29 per cent who had no significant emotional or mental abnormality.

These figures, of course, do not suggest that this degree of psychological morbidity would be found in any random group of drivers involved in accidents. Only the more serious and more suspect problem drivers are selected for referral to the clinic.

In my own clinical experience very few of my psychotic patients have been involved in accidents. Recently, a hypomanic patient, a week after being removed from a local psychiatric hospital against medical advice, led the New York police in a frantic 90-miles-an-hour chase through Manhattan. Rarely a depressed patient commits suicide by driving his automobile off a bridge or over an embankment. They do not, however, generally involve others in such heroics.

In some jurisdictions driving licenses are automatically suspended when patients are sent involuntarily to a psychiatric institution. New York University brought some of the country's experts together last year to discuss the medical aspects of motor vehicle accident prevention. The Committee on Psychiatric and Psychological Aspects, headed by Dr. Herbert Gaskill, could not agree on the role of previous mental illness in licensing.

Psychoneurotic patients may experience great discomfort in driving, but rarely endanger anyone. An anxious, claustrophobic individual may drive an abnormal distance away from a curb or the side of a bridge, but at most he is likely to scrape another car's fender. It is claimed that most over-anxious drivers drive too cautiously and are incapable of quick and decisive action in a traffic emergency.

The correlation of intelligence level with safe driving is not high. Many defective individuals have excellent records. Perhaps they are less likely to be distracted by their thoughts and by day dreaming. One of my friends, a Ph.D. in philosophy killed two children with his automobile. I went to high school with this fellow and he was often the butt of the group. He was always lost in the clouds. One might have predicted then, because of his extreme absent-mindedness and abstraction, that he would make an inefficient driver. Certainly in the complexities of modern urban traffic, idiots and imbeciles should not be permitted to drive. But there must be few if any who attempt to do so.

Any general denial of the right to drive to individuals with peripheral nervous system lesions would be unjust. Howard Rusk has stated that paraplegics who drive have outstandingly fine records and deaf mutes are said to have the best driving records on the Pennsylvania highways.

Fatigue is of real importance as a cause of accidents, but it is difficult to evaluate. It is

apparently of more importance in the driving of private cars than in commercial vehicles, since the Interstate Commerce Commission strictly limits hours of continuous driving. Statistics have shown that in commercial vehicles the accidents tend to occur in the early period of driving rather than in the late period.

Persons with organic brain disorders, except in rare special instances, should not be permitted to drive. Since paresis has happily become a rare disorder, the bulk of these individuals are cases of senile deterioration. And with increased longevity these cases are certain to become more numerous.

In all of the current statistics, the incidence of accidents to drivers over sixty-five is formidable, particularly when one considers the fact that these individuals drive far less distance annually than do younger drivers. Several experts have suggested periodic relicensing physical examinations for persons in this age group.

I understand from Dr. Russell Fisher that Dr. Goddard, of the U. S. Public Health Service, recommends a physical check-up every five years for drivers from fifty to fifty-nine, every three years for drivers from fifty-nine to sixty-nine, and annually for those over that age. Psychiatric consultants should be readily available to these examiners.

The problem of the epileptic driver has long been a focal point of interest. It is one of the subjects of major consideration in an excellent book recently published, "Epilepsy and the Law." This work is the joint production of Roscoe Barrow, Dean of the University of Cincinnati Law School, and Dr. Howard Fabing, a Past-President of the American Academy of Neurology.

All of the states, except South Dakota, either deny epileptics drivers' licenses or issue limited licenses under special conditions. The Committee on Neurological Disorders in last year's meeting on traffic accident prevention at New York University was headed by Dr. Wolff. Its report points out that states that have adopted machinery for carefully screening individuals with epileptiform disorders have greatly reduced the frequency of traffic accidents in those individuals. In Massachusetts there have been none during the past three years, while during the same period there have been 265 fatal accidents, in which the driver was under the influence of alcohol.

Most of the members of that committee felt that epileptics should be entirely free of seizures for eighteen to twenty-four months before being granted temporary and provisional licenses. Some of the members advocated a three-year period of freedom from attacks. Dr. Wolff and some of the committee members were of the opinion that a history of seizures, excepting those that occurred only in infancy, should disbar an individual permanently from driving public vehicles, and Dr. Wolff felt that this drastic restriction should also apply to drivers of commercial vehicles.

With the great advances in aneleptic therapy, fifty per cent of epileptics should be kept entirely free of all attacks and in thirty per cent they should occur only very rarely. It has been found hazardous to rely on the presence of a prolonged aura to warn consistently of an oncoming seizure, because of occasional instances in which the accustomed aura has, for some inexplicable reason, failed to occur.

But all of these entities about which we have spoken account for only a small portion of accidents. The great bulk of the accidents are caused by the normal or near normal individual who does not merit a special psychiatric label, but has, in a high proportion of cases, certain socially undesirable personality characteristics. On this fact all psychiatric and psychological studies of accident drivers are agreed.

Dr. McFarland, of the Harvard School of Public Health, after studying the problem for some years has concluded that no single characteristic has been isolated in people with poor driving records.

He believes that the most significant findings are:

1. Prior accidents. Many other workers have included frequent moving violations, even though they have not resulted in accidents.

2. General instability of relationships with social institutions and society as a whole.

3. A personality structure marked by eccentricity, impulsiveness and mildly psychopathic characteristics.

McGuire, who has published several traffic violation studies in the Armed Forces Medical Journal, has found that the accident-free individuals tended to be "more mature, more conservative, more intellectual, more thoughtful, to have a higher aspiration level and to have had a happier and better adjusted childhood than did other drivers."

Professor Perin, of Miami University, writes, "Careful analysis of driving characteristics, accidents and human qualities leads us inescapably to the conclusion that the bulk of the psychological problem lies in the emotional and in the broader personality side of the individual. Unfortunately, this is the most difficult of all to investigate and to understand. Wrapped up here we have all of the personal motives, the individual conflicts, the frustration reactions, the wishes and the desires. When considered in the light of the constant change the human being is undergoing, we see why it is so very difficult to predict driver performance."

One of the best researches on the personality make-up and background of poor drivers was a Canadian study that appeared in the American Journal of Psychiatry in 1949, by Drs. Tillman and Hobbs.

They compared a hundred bus and taxi drivers who had four or more accidents with a similar number who had been accident free. They found that the high accident group had a "marked intolerance for, and aggression against any authority, dating from early childhood. The origin of this aggressiveness is to be found in an unstable home background." There was a high divorce rate among the parents of these drivers and one or both parents had been overstrict. The drivers themselves had had a high truancy rate in school and frequent juvenile court appearances.

Professor Lennep, of Utrecht, Holland, a noted psychologist, believes that "the good driver is one entity with his car, it is an extension of his own body." It has been clearly demonstrated that a man drives as he lives, or as Professor Lennep phrases it, "I drive precisely as I am."

He says that there are three elements vital to good driving:

1. The driver must pay close attention to the traffic situation as it is *for him.*

2. He must be constantly considering the intentions of drivers ahead and around him.

3. He must realize constantly what his own car and his own behavior means to other users of the road.

He states that preoccupation is the number one enemy of safe traffic and that a high sense of responsibility is the chief asset of the good driver.

The psychologist Frederick L. McGuire has been experimenting with a paper-and-pencil test, which he terms the Safe Driver Inventory. This consists of eighty-nine items and can be administered to individuals or groups. Unfortunately, the test does not appear to be discriminating enough to be of any practical value to a licensing board. Perhaps it will prove to be valuable to some agency, such as one selecting drivers for school buses, if there is a great excess of applicants. If the cut-off score in this test were set so high that one would have ninety-five chances out of a hundred of getting only safe drivers by using it, fifty-six safe drivers out of a hundred would be disqualified along with all but five per cent of the unsafe drivers.

Finally, let us consider the drinking driver. Attitudes toward individuals who use alcohol differ widely. Many consider them just bad

actors, while others consider most of them sick people. But no one can deny that the individual who drives a car when he is under the influence of alcohol has defective judgment and is a menace to himself and to others and that ways must be found to deter him.

Certainly the best deterrent is the threat of punishment. In many types of crime the threat of punishment has a questionable effect. But there are other crimes in which I feel certain that it has great prophylactic value, and drunken driving is one.

Caesar Beecaria, an Italian economist and jurist of the Eighteenth Century, published his remarkable Treatise on Crimes and Punishment two hundred years ago. He said that the most effective crime deterrents were speed of capture, certainty of conviction and equality of punishment.

Criminals as a group are "blooming optimists." They feel "this time I'll surely get away with it." This is peculiarly true of alcoholics. They are almost without exception individuals who do not face reality. Alcohol has been termed a social lubricant and a superego solvent. It might also be termed the prime evading reagent. To get people to stop driving when under the influence of alcohol, they must be convinced that they will be caught, convicted and severely punished.

I am convinced that the most effective means that we have for convicting the drunken driver are the chemical tests for the determination of the blood alcohol level. Twenty-four states have instituted these tests, and I am reliably informed that none has ever abandoned them when they were once instituted.

Let me say just a few words about them, for we have on the platform Professor Farinholt, whose views on the legality of these tests are far more authoritative than mine, and Dr. Russell Fisher, a nationally recognized expert on the scientific basis of these tests. Although Dr. Fisher is not a regular member of this panel, I feel that questions dealing with this subject should be addressed to him, and I feel certain that he will be happy to answer them.

As you probably know, these tests have been sufficiently used so that generally accepted standards have been established. A blood alcohol content of less than 50 milligrams per 100 cc. is considered to be innocuous; 50 to 150 milligrams per 100 cc. marks an uncertain zone, in which heavy reliance must still be put on observation by the arresting officer and other competent observers. When the blood alcohol level is above 150 milligrams per cent the legal burden is felt to shift and the accused driver must prove that he was not under the influence of alcohol.

The test results should not be interpreted automatically, since it is well recognized that there are individual differences in reactions to all drugs. But if one has spent much time in observing trials, one realizes that the vagaries of drug reactions are *minute*, when compared to those of the human memory, the individual's powers of observation and witnesses' veracity.

There seems to be a common and perhaps largely unconscious fear of scientific police and scientific legal methods. People seem to feel that these will somehow rob the accused of his sporting chance in his contest with the law, and that they tend to dehumanize legal procedures. It is important to hold in mind the fact that blood alcohol determinations do not only aid greatly in convicting the guilty but they also exculpate the innocent.

It would be an interesting study of the legislative process to determine why the bill legalizing blood alcohol determination has been introduced into the Legislature during the past five sessions and on each occasion has been defeated, apparently largely due to the efforts of one legislator. Why the Baltimore Sun, with its enlightened social attitude toward many problems, has been in opposition is an equally puzzling problem.

A word of caution might be added in regard to the effect of other nervous system depressants

on driving efficiency. The effect of the barbiturates, the anti-histaminics and the new tranquillizing drugs vary greatly in individuals and with the dosage employed. The physician must assume an important responsibility in prescribing these drugs to persons who drive and must caution them accordingly.

In summary, I should like to make the following recommendations:

1. The establishment of an accurate record of individual traffic offenders and its ready availability to trial magistrates, along with the individual's criminal record, when legal disposition of a traffic offender is to be made. No psychological test is as revealing in testing a man's social responsibility as his past record of legal conformity or non-conformity.

2. A legislative enactment providing for blood alcohol determinations in individuals suspected of driving under the influence of alcohol.

3. The withholding of drivers' licenses from all epileptics unless they are under regular medical surveillance and have been entirely free of attacks for two years. (The present period of three years seems excessive. Maryland is the only state requiring this long a period of freedom from attacks.)

4. Regular and frequent medical examinations of drivers over sixty-five years of age, including a psychiatric appraisal, to detect significant physical or mental deterioration.

5. A study to determine the advisability of establishing in Baltimore a Traffic Clinic staffed by psychiatric and psychological personnel for the examination of problem drivers. This could be established in conjunction with the already existing Court Clinic of the Supreme Bench, as is the case in Detroit, or it could be entirely separate.

A study of the Detroit Traffic Clinic was recently made by a group from Chicago, and subsequently a Chicago Traffic Clinic was established.

6. There is so much that we do not as yet know about this staggering problem, that there is an obvious need of continuing research of the highest caliber by workers in several disciplines. Every support should be given to it.

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JUDGE BYRNES: Thank you very much, Dr. Guttmacher.

We will hear from Dr. Guttmacher later when we have the question-and-answer period.

I was very pleased to hear Dr. Guttmacher speak with such high approval of some of the bills that were introduced in the Legislature dealing with the problems that we have before us at this time, one of them being the blood test for alcoholism. I think it passed the House, but it did not pass the Senate. Incidentally, it did not call for an involuntary taking of the blood, but simply provided that the alcoholic content shown in the blood would be admissible in evidence.

Dr. Guttmacher referred to the preoccupation of drivers.

Sometime ago in court, I recall one of those cases where the light was green for north-and-south traffic and also green for east-and-west traffic—and both drivers, of course, had the green light. One of the drivers was a very elderly person, and Gil Prendergast was cross-examining him. Now, Gil is a very gentlemanly individual, and he was not too rough on the old gentleman. He said, "Now, when you approached the light, were you looking at the light or were you talking with your wife, sitting on the front seat?" The old gentleman replied: "No, I was looking at the light." and Gil said, "Are you sure you were not talking to your wife?" And the old gentleman got somewhat peeved, and looked at me for protection. He shrugged his shoulders and said, "Judge, we have been married for thirty-two years. There was nothing to talk about."

Now, ladies and gentlemen, the remaining topic of the panel is that of the legal aspects of traffic accident prevention, and I know of no

better person that we could have for our speaker than Professor L. Whiting Farinholt.

Professor Farinholt is a graduate of Johns Hopkins University, where he received an A.B. degree. He received an LL.B. degree at the University of Maryland Law School, and a Master's degree at the Harvard Law School.

He is at the present time professor of law at the University of Maryland Law School. He teaches Conflict of Laws, torts and medical-legal problems.

He is a member of the City, State, and the American Bar Associations, the American Judicature Society and the American Law Institute.

He will discuss some of the questions that I am sure are of interest to you.

He looks like a college professor, he has the dignity and the learning of a college professor, and I am pleased to hear his close friends call him Whitey.

Professor L. Whiting Farinholt.

LEGAL ASPECTS AND PREVENTIVE MEASURES

L. W. FARINHOLT, JR., ESQ.*

JUDGE BYRNES: There is always a danger when one addresses a group composed of members of two disciplines, that the speaker's remarks will be found to be either exceedingly elementary or exceedingly perplexing, depending upon the profession of the listener. That is the risk that must be run, however.

It is well known, our population faces three primary causes of death: heart disease, cancer and accident. By far the most numerous of the accidental deaths result from the motor vehicle. Add to this, those who are temporarily or permanently disabled because of traffic accidents and the statistics become astronomical. But figures, at least those of the type of which we are speaking, are cold and inhuman and perhaps do not bring about a realization of the enormity of the issue before us here tonight.

I would like you to picture, if you will, the Baltimore Memorial Stadium filled almost to capacity for an opening game. The number of people in that capacity crowd, roughly 40,000, is the number of people killed last year by automobiles. Two and a half times that number were permanently disabled. Picture all the inhabitants of the City of Baltimore, together with the residents of many its environs and suburbs; gather together in your mind's eye 1½ million people, and that is the number who were injured seriously enough to require hospitalization last year. Per year, every year, this occurs. Admittedly, this is quite a mass of suffering humanity.

Put aside concern for the human element, and from a purely financial standpoint, try to imagine the yearly dollar loss, beyond the medical and hospital expense, to production alone because of absence of accident victims from productive work. That cost is appalling.

The problem is immense and the cause is complex. It permits no panacea, yet something must be done to reverse a trend which, if it continues, would subject every family to a statistical likelihood of sooner or later experiencing death or serious injury resulting from an automobile accident.

An automobile accident involves the interrelation of three basic factors: the road, the vehicle and the operator.

As to the highway itself, the state and the federal governments have met, and are meeting this challenge quite effectively. Assuming that other factors are equal—a rather fatuous assumption—the roadways of today are safer by far than those of a generation ago. The dual and divided highways, the clover-leaf intersection,

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the varied systems of signals and signs are all effective measures in promoting road safety.

However, the remaining two factors have not improved proportionately. I shall not deal with the safety features of the vehicle, since this meeting provides a forum for the doctor and lawyer rather than the engineer or physicist. However, very briefly, I would like you to consider whether the manufacturer of the car of 1957 with its wrap-around windshield that necessarily distorts the driver's vision, its instrument panel with a number of gadgets that have the added disadvantage of contributing to head and face injuries in a crash, has a major concern with safety. Power, speed, and what is euphuistically termed styling, would seem to be the aim of the majority of manufacturers.

Whether a state or federal government could compel a car manufacturer to comply with certain minimum safety devices is not particularly pertinent to a discussion before this group. However, it seems clear that it is well within the power of the state to do so, in the same manner as the state requires certain lighting signals, horns, braking systems and safety glass on automobiles driven on state highways.

It is with the final and most important contributing factor to traffic accidents, the operator, that we are here primarily concerned. Our problem is to educate, to limit, or if need be, to eliminate the inadequate drivers by some method which I hope will be less drastic than death on the highway.

The state has the power to limit or refuse licenses to drive. The use of the highways is simply a privilege granted by the state to its citizens and not a right. The so-called "right to drive" a motor vehicle in public places is not a natural and unrestrained right, but a privilege subject to reasonable regulations in the interest of the public under the police power of the state.

The concept "police power of a state" may be defined as a power to enact and enforce laws for the protection of the health, safety, morals and the general welfare of the people. The Supreme Court of the United States has often recognized the power of the state to require one using its highways to submit to the state's authority.

Thirty-two years ago, in the case of Hess vs. Pawloski, the Court said, "In the public interest the state may make and enforce regulations reasonably calculated to promote care on the part of all, residents and non-residents alike, who use its highways."

The case from which I quoted specifically dealt with the right of a state to require anyone who drove an automobile, characterized by the Court itself as "dangerous machine . . . even when skilfully operated," to subject himself to the jurisdiction of the state in a civil action arising out of the operation of a car within the state.

The state may establish and enforce rules governing the operation of an automobile under its police power, so long as the regulation has a reasonable relation to public health and welfare. There is little question, therefore, that the State of Maryland has the power to enact and enforce rules concerning the construction of automobiles to be used on our highways, to regulate safety equipment, to establish any reasonable regulation concerning licensing of car or driver, and to revoke or suspend such license.

The major limitations upon the Legislature in this field would seem to be that the proposed standards must relate reasonably to the promotion of safety and that there be no discrimination in the classifications of those subjected to such standard. The operation of a motor vehicle upon the roads of Maryland is but a privilege which the State can grant or withhold at its pleasure. What the State may withhold altogether it may grant upon a reasonable condition.

What are the present limitations upon the operation of a car in Maryland? Article 66½, Sections 235, et seq. of the Maryland Code prescribe the mechanical standards of the vehicle and establish regulations concerning

lights, warning devices, brakes, safety glass, and so forth.

In Maryland we do not require safety belts, dashboard padding or many of the recently recommended safety features. There seems to be no question as to the constitutional power of Maryland to require all vehicles operated upon our highways to be so equipped. This is a matter of education of the public and its representatives in the Legislature since the enactment and enforcement of standards of this type would seem to be quite clearly within the police power of the State.

Also in Article 66½, Section 85 and following, the Maryland Code provides the physical standards which the operator must meet in this State.

In company with all states, except North Dakota, Maryland requires an examination of the applicant for a driver's license and confers on the Commissioner discretion to deny a license to anyone deemed to be an unsafe driver.

The Code provides:

"The department shall examine every applicant for an operator's or chauffeur's license . . . It shall include a test of the applicant's eyesight, ability to read and understand highway signs regulating, warning and directing traffic . . . and shall include an actual demonstration of ability to exercise ordinary and reasonable control in the operation of a motor vehicle, and such further physical and mental examination as the Department finds necessary to determine the applicant's fitness to operate a motor vehicle safely upon the highways."

By this section, Maryland aligns itself with those states which authorize under certain circumstances, but do not require in each case, a physical examination to determine the fitness of the applicant.

We have certain regulations—I do not want to take the time to read them all—forbidding the issuance of a license to an habitual drunkard, one who is addicted to the use of narcotic drugs, and so forth. We also provide for the appointment of the Medical Advisory Board, of which Dr. Kinnamon is a member, and to which he has referred. By these Sections we see that Maryland authorizes, but does not compel a physical examination for all applicants.

But how are the physical and mental qualifications of the driver applicant passed on in actual practice? Since Maryland does not require a compulsory physical examination of each driver applicant, the only way in which the licensing officials can discover if the applicant is suffering under any disability is through the application itself.

In Maryland, as you have already learned, the application for the learner's permit poses the following questions: "Have you ever been treated for fainting or dizzy spells, epilepsy, heart trouble or paralysis? If answer is yes, give full particulars, and submit a doctor's certificate. Do you have, or have you ever had any mental or physical incapacity or infirmity? If so, give particulars. Are you crippled in any manner? If so, give particulars."

That is a rather vague and almost useless method to determine what disabilities an applicant may have.

Therefore, Maryland does in some instances, leaving out only those instances in which the medical examining board is requested to make an examination, provide a compulsory physical examination of driver applicants. But the only examination is that which I have already mentioned under the above circumstances: that is, those where the disability is obvious; those where the applicant states in his application that he is suffering under some physical or mental incapacity; or under a recently enacted statute, medical examination may be required of drivers whose licenses have been revoked or suspended after an accident or where the arresting officer suspects a medical reason for the accident.

But the question remains, does this system as set up under the Maryland law actually lead to a satisfactory solution of the problem before

us? In effect, the questions as stated in the Maryland application cover only a small proportion of those defects which could seriously limit efficient driver performance. The application does not cover a number of physical or mental conditions which could seriously impair driving ability.

And I would like to add that even if the application form were enlarged to cover a wide variety of defects, it is questionable whether such a procedure would give us the solution to the problem. Only those applicants who have been under a physician's care for specific defects would be capable of answering the questions, and the large majority who had not been treated by physicians would slip by the examiner.

Furthermore, since the driver's license is of great importance to many people, there would probably be a tendency to falsify applications, a tendency to go underground, as it were.

Therefore, it seems that the only practical way in which the defective driver can be effectively screened is to require a compulsory physical and mental examination of each applicant, a procedure which constitutionally could be required as a condition of the issuance of a license. The scope of the examination could be determined after study by interested members of the medical profession.

I have been limited to a twenty-minute presentation. It is an impossible task to compress an adequate discussion of this immense question into such a short period of time, but I would like to present a few specific suggestions out of the many which might be made.

A group study should be made in which the reports of already existing organizations would be correlated, together with independent investigation, with a view toward making specific recommendations to the Legislature for its consideration and enactment into law.

Among these recommendations, I am hopefully anticipating the following:

First: At the time of the original application, require a stricter physical examination, one which would bring to light disabilities which, under the present practice, are not divulged either by the application itself or by the present cursory examination. Perhaps one improvement would be a requirement that a more complete examination be made by the applicant's own doctor and that his certification accompany the application. At any rate, a more effective method than is used at present must be developed to discover latent disabilities which are likely to precipitate a motor vehicle accident.

Second: Require relicensing and re-examination at specific age levels. For example, every five years after fifty; every two years after sixty; and annually after sixty-five. Furthermore, the examination should include mental as well as physical tests.

Third: Require relicensing and re-examination at other relevant occasions. I have in mind, after involvement in any reportable accident—which is an accident in which death or personal injury occur, or where the property damage amounts to more than an amount specified by statute, I think today it is $75. The re-examination should be required without reference to culpability or civil or criminal liability. An accident has occurred. There is a cause. Perhaps the precipitating factor is a physical or mental deficiency or even an emotional attitude that can be discovered through an adequate examination. Corrective therapy or other remedial procedures can be demanded as a condition of reissuance of the license. The burden of demonstrating his competence to drive would be placed on the operator.

I have spoken of a physical and mental examination. The Maryland statute provides that a "mental" examination may be required upon the original application for a license. However, in practice the usual examination tests little more than the intellectual capacity to read the highway signs and understand to a minor degree the traffic regulations of the State. I would recommend the administration of simple psychometric tests to all who apply originally for a license.

Further, I would advocate a number of projective tests aimed at measuring emotional stability, to be administered to those involved in "moving violations" of the traffic laws, and those involved in reportable accidents, regardless of fault. The result of these tests should be made a part of the operator's record upon which revocation, suspension or reissuance of the license would be based.

I would strongly recommend—and this is the fourth point—that there be provided legislation for compulsory chemical testing of intoxication of operators of motor vehicles and that the results of such tests be admitted as presumptive evidence of intoxication in criminal cases.

The group here assembled conducted a symposium on the question of chemical testing for intoxication only a few years ago, and it is perhaps not necessary to repeat the issue in detail. However, briefly, to refresh your memories, the proposed legislation would provide that a finding of .15 per cent or more of alcohol in the blood would give rise to the presumption that the person was "under the influence" of alcohol. This would be admissible as partial proof, subject to rebuttal by the defendant, in the courts.

For a number of years proposed legislation has been before the General Assembly of Maryland at Annapolis, but approval has been denied, for reasons that escape me.

I would like to emphasize in this connection several points: (1) there is a definite statistical correlation between intoxication and death or injury by automobile; (2) the validity of the proposed testing procedure is generally accepted; (3) similar legislation has been adopted by statute in twenty-four states, and by case law in eight other states; (4) such legislation has been determined to be not violative of constitutionally protected civil liberties; and, finally (5), a point often overlooked, the test can prove innocence as well as guilt. According to the National Safety Council, there are over one hundred pathological conditions which may cause a driver to appear intoxicated even though he has not had a drop to drink.

To recapitulate:

Stricter examinations, both physical and mental, upon the original application for license.

Repeated examinations—both physical and mental—at specific occasions throughout the operator's driving career.

The adoption of the model statute on chemical tests for intoxication.

These are only a few of the suggestions that one might make. Of prime importance to implement these suggestions, is the designation of a group representing the disciplines here present to study and formulate proposals for legislative enactment. In no area can I imagine a more necessary cooperative effort between our two professions—two professions which we sanctimoniously and pontifically proclaim to be for the welfare of our fellow man.

Lombard and Green Streets
Baltimore, Maryland

JUDGE BYRNES: Thank you very much, Professor Farinholt.

Now, ladies and gentlemen, we will take a few minutes to give the committee an opportunity to select the questions.

We will take your questions and give them to the members of the panel to answer. In addition to your questions, as we have a panel of experts here, we will have our own quiz test, and this test will be given along with the questions handed in. Your questions will be given to the person to whom directed and who, I am sure, will be able to answer it. This makes it a bit different from the usual quiz test.

QUESTION-AND-ANSWER PERIOD

JUDGE BYRNES: This is a question addressed to Professor Farinholt:

Which States have examination for eyesight which require 1) depth perception, and 2) color perception?

PROF. FARINHOLT: Judge Byrnes, if I may, I would like to give you the number rather than the names of the States, because a test for depth perception is applied in eighteen or nineteen states.

As to Maryland, I can find nothing in the statutes specifically setting out a test for depth perception. However, I am told by the Commissioner that a stereopsis evaluation is required if visual acuity is below 20/70.

As to color perception, thirty-nine states have such a test. In Maryland, as long as the applicant is able to distinguish green from anything else, his license is unrestricted. On the other hand, if he cannot distinguish green from amber or red, he is limited to day driving.

JUDGE BYRNES: This is addressed to Dr. Kinnamon.

Is there any indication that these requirements prevent accidents?

DR. KINNAMON: Sir, in Maryland, in 1956, according to the report summary on motor vehicle traffic accidents, there were 31,217 accidents. In that number the driver's eyesight was defective in 59 cases, which would make a very small percentage.

JUDGE BYRNES: Professor Farinholt is asked another question along that line.

Are they enforcible?

MR. FARINHOLT: Yes, those tests would be enforcible. After all, driving an automobile is again only a privilege and not a right, and any reasonable regulation may be imposed. Fundamentally the State, under the police power, may regulate for the public welfare, health and morals of the public.

There are two limitations. There must not be any unreasonable discrimination as to the class of persons tested or refused because of the test. And, secondly, the test must be reasonably related to the safety and welfare of the public. Now, whether or not the test is a valid test which applies to safety is really a medical question and on this medical advice would be essential.

JUDGE BYRNES: Now, the next question is directed to Dr. Guttmacher.

Is there any evidence that the repeaters in traffic accidents have a high incidence of law violations or other indications that they are psychopathic problems?

DR. GUTTMACHER: I think the slogan that a man drives as he lives is certainly true, and there is a high incidence of disregard for legal restrictions in the behavior of people involved in accidents. I do not mean to say that all people in accidents have this factor, but a much higher percentage of people involved in serious accidents have a record of disregard for the restrictive code by which those of us in a highly-organized community must live.

JUDGE BYRNES: This is addressed to Dr. Kinnamon.

In your opinion, is the alcoholic who becomes highly inebriated and drives in any way different from the alcoholics who do not risk theirs and other people's lives?

DR. KINNAMON: Sir, I am going to refer that to Dr. Guttmacher.

DR. GUTTMACHER: Well, I think that is exemplified in the old adage, *in vino veritas*. We all know people who even when drunk behave like gentlemen. We all know people who everytime they get drunk become insulting. Alcohol does not produce new characteristics in people; it merely releases the underlying characteristics.

There are people I think who even when drunk will drive with a certain degree of caution. And there are people, of course, who won't drive at all under the influence of alcohol. And then, there are people who drive recklessly on the road when they are under the influence of alcohol.

I think that it is a situation influenced primarily by the person's own basic personality structure.

JUDGE BYRNES: Professor Farinholt, you are asked this question.

Are not compulsory chemical tests for intoxication an infringement of civil liberties; specifically self-incrimination?

MR. FARINHOLT: This is probably one of the reasons why there is such an objection to the adoption of the proposed legislation.

I think I can answer the question rather quickly, and I will do so without going into it too deeply.

Self-incrimination is protected from the Federal Government by the Fifth Amendment, in that no person is compelled in a criminal case to be a witness against himself.

That is protection against the Federal Government. But even the Federal Government, however, in a case in 1910, in which Mr. Justice Holmes wrote the opinion, stated that the prohibition against compelling a man in a criminal case to be a witness against himself is with reference to a compulsion to extort a confession or communication from him and not the "exclusion of his body as evidence when it may be material."

Now, Maryland has a section in the Declaration of Rights, article 22, which is substantially the same as the Fifth Amendment. We have interpreted our Declaration of Rights in the same manner as Mr. Justice Holmes interpreted the Fifth Amendment.

With reference to our Maryland rule against self-incrimination, I would say about as follows, that where the physical evidence is obtained before trial, and testimony based thereon is given in court by another person, a third party, there is no violation of the privilege against self-incrimination.

I might add at this point, though your question was specifically directed to self-incrimination, there is another constitutional question, as you will find, with respect to unreasonable searches and seizures. There is no flat restriction on allowing searches and seizures of an individual *following arrest.* The evidence so obtained is admissible in both state and federal courts.

In the majority of the jurisdictions, including Maryland, but not the federal courts, pertinent evidence, no matter how obtained, may be admitted in evidence against the accused. However, in Maryland by legislation enacted in 1920 known as the Bouse Act, evidence obtained through illegal means is inadmissible in misdemeanor cases.

The cases with which you would be primarily concerned here would be misdemeanors. House Bill 13, the bill recently before the Legislature, provided that the results of any such tests would be admitted in any court of this State as presumptive evidence; thus, if the proposed statute is adopted, the Bouse Act interpretation would be avoided.

I would suggest that attorneys who may be interested, make a further study of the often advanced argument that compulsory chemical testing is a denial of due process. This point was fully discussed, and the argument of denial of due process dismissed, in a most recent opinion of the Supreme Court, concerning compulsory chemical tests for alcohol, the case of *Breithaupt v. Abram,* 77 Supreme Court Reporter, page 408.

JUDGE BYRNES: Dr. Kinnamon, do you have any idea as to the cost of adopting recommendations for compulsory tests for intoxication? And are such recommendations enforcible?

DR. KINNAMON: First, as far as the costs are concerned, I cannot answer that question. But when you compare the cost to the money saved and the lives saved, I do not feel that the cost of the tests themselves, the equipment, and so forth, should enter into it.

I feel that as Dr. Fisher has had this problem before him, that he would be able to offer an opinion as to the actual cost.

JUDGE BYRNES: Dr. Fisher, would you care to comment on that?

DR. FISHER: I can tell you of the recommen

dation of a special committee study made four years ago.

It dealt with the first year of the use of the chemical test program on a voluntary basis—that is, not compulsory—but, nonetheless, one in which legislation was requested to have the test performed on every individual involved in a serious accident, and it was estimated that 1,000 analyses would be done in the first year in Maryland, and that the basic cost involved in obtaining equipment would be $14,000 and that the operating cost per year, including sufficient personnel to handle expert testimony in court, would be $11,750.

In other words, it would cost something like $12 per test to have it done and brought to the court where it could be used. If the number of tests were doubled, the cost would be below $10 per case.

JUDGE BYRNES: Dr. Guttmacher, what are the chances for the development of psychological tests to pick out real problem drivers?

DR. GUTTMACHER: I referred very briefly to some work that has been done on Psychological tests—none has been devised so far that is very practical.

On the other hand, I do think there is much to be said for the establishment of a psychological, psychiatric and medical clinic to intensively study problem drivers. They also do a lot of educational work. I do not think that the purely psychological test is yet developed sufficently, and perhaps will not be for some time, to really discriminate accurately enough.

I think any test that is going to rule out a fair percentage of your problem drivers is also going to be very unfair, in that it will rule out a fair percentage of your non-problem drivers.

As I said, Detroit has such a clinic. The traffic division of their court clinic has on its staff two psychologists and one or more technicians, a psychiatrist, a physician to do the physical examinations and a secretary. They examine over eight hundred cases annually, on a budget of $48,000.

JUDGE BYRNES: Doctor, I have another question for you.

Do you feel that doctors should have to report patients who have epilepsy and who drive?

DR. GUTTMACHER: Well, this is a moot question. There are seven states which require reporting of epileptics. Dr. Kinnamon has said that epileptic drivers should be reported.

The great difficulty, of course, with this type of thing is that people go underground. That is, the man who has epilepsy, or fears he has epilepsy, will not seek medical help, because he is afraid that if he does the physician is going to report it to the authorities and he is then going to lose his driver's license.

This is a very serious phase of the problem. If we should have such an enactment, it would certainly be necessary to widely publicize the fact that if the man remains under treatment and his attacks do not recur, that then his driver's liscense would be restored to him.

But even so, there is a group of people who fear more harm than good would come out of this, because of the fact that the epileptic driver would just go underground and would not seek medical help. That is one side of it. I certainly cannot express a definite opinion. It certainly has two sides.

JUDGE BYRNES: Professor Farinholt, does the State have the power to require automobile manufacturers to incorporate specific safety features such as safety belts, and so forth?

MR. FARINHOLT: Yes, sir, without question. And we have earlier done so in several instances, in the requirement of safety glass, braking devices, lights and that sort of thing.

And as long as the required device has a reasonable relation to safety, the State would have, I think, complete power under its police power, to enforce the use of such safety devices.

JUDGE BYRNES: Dr. Guttmacher, should the driver's licenses of patients sent to psychiatric hospitals be suspended temporarily?

DR. GUTTMACHER: That is another one of those moot questions.

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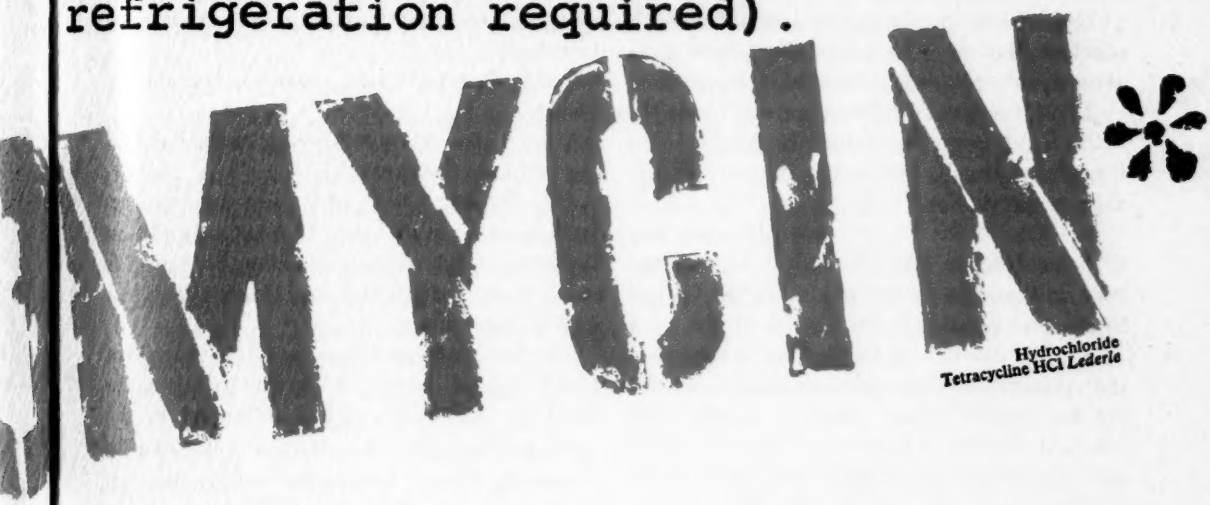

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This is done in a small number of states. But it seems to me, from my own experience, that the number of people who after leaving a psychiatric hospital become involved in driving accidents is so small that I again fear that there is more danger of discrimination against a group of individuals who really do not present any problem of this kind. Again, it might keep people from being hospitalized, with the fear of those whose livelihood depends on their ability to drive that their licenses would be taken away from them.

Again, I have no strong conviction about this problem. But my fear is that more harm than good would come from this kind of injunction.

JUDGE BYRNES: Dr. Kinnamon, other than the Medical Advisory Board, has the Medical and Chirurgical Faculty been active in motor vehicle accident prevention?

DR. KINNAMON: Sir, the only other function that the Medical and Chirurgical Faculty has been involved in is the study of the Cornell Study, and assisting in the Cornell Study.

It is the function of the doctors to report on special forms any automobile accidents, describing the type of injury, the part of the body involved, the type of fracture, the type of wound, and if the accident is fatal, the cause of the fatality.

JUDGE BYRNES: Dr Kinnamon, I have another question here for you.

Concerning the Medical Advisory Board, when a patient is seen and needs further study to whom is the patient referred?

DR. KINNAMON: That problem has come up a number of times. The patient is referred back to the individual's family physician, with any recommendations that we have.

JUDGE BYRNES: Now, here is another question for Professor Farinholt.

Is there any study at present on teen-age driver problem?

MR. FARINHOLT: I know of none, though I would like to ask the rest of the panel to comment on that.

On the other hand, at this moment I would like to urge the establishment of some sort of a group that would study not only teen-age problems but all the other facets of this immense problem.

Do you have any knowledge of teen-age studies?

DR. KINNAMON: Dr. Guttmacher mentioned a number of them. We have a local one that the State police have been doing, and there is one that we are working on now, and which I am hoping Major Randall of the State police will be able to carry out for us, strictly dealing with teen-agers.

JUDGE BYRNES: I have a question here for Dr. Fisher.

What is the relation between cocktail drinking and auto accidents?

DR. FISHER: There have been two general studies of that in this area. I cannot answer it on the basis of the cocktail drinking, because this could mean anything from one before dinner to a quart before dinner.

The first study was based upon an analysis of blood alcohol levels in drivers involved in accidents and drivers picked at random at the same hour of the day. It was conducted in Evanston, Illinois, and it was shown that the people who were under the influence were apt to be involved in serious accidents fifty-five times as frequently as the non-drinkers.

In the second, or Toronto study, they broke it down a little further. They found no significant difference between the people who were non-drinkers and those who had a couple of cocktails (0.05 per cent or less alcohol in the blood). In people with blood alcohol between 0.05 and 0.15 per cent, lumped together, their statistics were something like one and a half, to two and one-half times as accident-prone.

In the statistics, comparing other drivers at the same moment passing by the scene of the accident with people whose blood alcohol was 0.15 per cent and above the drinkers were nine

and seven-tenths times as apt to be involved in an accident as were the non-drinkers.

So it means that if you are accident-prone, the probabilities are many times greater that you will be in an accident if you go out of here and consume alcohol to reach 0.15 per cent or more than if you go out of here and do not have anything to drink.

JUDGE BYRNES: Here is another question for you, Dr. Fisher.

Has the medical profession made any effort to procure legislation requiring blood alcohol or breath alcohol tests? If so, what has been the result?

DR. FISHER: That question has been answered previously. There has been isolated support by individuals in the State who are familiar with the chemical tests, theory and practice. They have spoken in support of this legislation, but there has been no State faculty or medical society action, nor has there been any widespread activity on the part of doctors in favor of this legislation. They have not shown any interest in the problem as a whole.

DR. KINNAMON: Dr. Fisher, do you know any reason why these forms of legislation have not gone through before now? They have been in legislation many years now.

DR. FISHER: I can recall four times, and beyond that I would like to say that in the last two sessions it passed the House. One time there was a vote of something like 120 to 3, or 120 to some small number, and the second time there was a vote again of over 100 in favor, and on each occasion it died in the Senate Committee.

It is perfectly obvious that some of the senators concerned are not convinced that it is good legislation. I think it is incumbent upon the people at large to find out a little bit more, and and if they are convinced it is good legislation to so impart this information to their senators.

JUDGE BYRNES: I think the next question is addressed to all the members of the panel. It is somewhat in line with Dr. Fisher's thoughts.

The question is, Don't you think that your recommendations might be presented to the legislative council and your entire panel, including Judge Byrnes, appear before the council, urging suitable legislation?

I don't know who might answer that one. It is addressed to all the members of the panel.

MR. FARINHOLT: I for one would be happy to appear.

I feel that one's appearance would have greater weight and effect if he were backed by a group appointed by this Joint Committee of the Bar Associations and the Medical Faculty and represented these bodies in their sponsorship of a study not only of the alcoholic problems but also of the other problems that we have mentioned tonight. I for one would be happy to appear in any capacity, at any place, at any time.

JUDGE BYRNES: Now, this question is similar to one that has been asked before. It is addressed to Dr. Guttmacher.

And the question is, Has the medical profession taken any effective action to educate the public and legislatures with respect to the need of legislation of this type?

DR. GUTTMACHER: I think that really has already been answered. I don't think I can add anything to it.

JUDGE BYRNES: Professor Farinholt, here is a question addressed to you.

In your opinion is there any legal basis for opposition to the adoption of chemical tests?

MR. FARINHOLT: None whatsoever, sir. I think that I covered that fairly well by indicating that there have not been any valid objections raised on the basis of self-incrimination, nor is there any basis for an argument founded on illegal searches and seizures. If such an act as we propose is adopted, the only obstacle, the Bouse Act, would be by the terms of the proposed statute, avoided. The only remaining argument is of a general character based upon denial of due process. I see little basis for such a contention.

May I take just a moment to state the reason for my position. In 1952 the opinion in the case of *Rochlin vs. California* was handed down.

There a stomach pump was used under rather violent circumstances to obtain narcotic pills from the stomach of an individual. The Supreme Court held that the use of such force and violence to obtain evidence was a bit too shocking. And I must agree. However, in the last two months, on February 25th of this year, in the case of *Breithaupt vs. Abram*, the Supreme Court upheld the right of a state to introduce as evidence of intoxication the results of a chemical test of blood taken from one who was unconscious at the time. The problems of due process, self-incrimination, illegal searches and seizures, and all the usual arguments against chemical tests for intoxication were presented and answered in favor of such tests and the introduction in court of the results as evidence of intoxication.

JUDGE BYRNES: Here is another one for you, Professor Farinholt.

How can evidence in a proceeding involving drinking be used as you suggest and meet our traditional American presumption of innocence until proven guilty?

MR. FARINHOLT: Well, I am afraid that there is some misconception of the effect of the proposed statute. If as a result of the chemical test it is found that the blood contains alcohol to an amount above 0.15 per cent, there arises a presumption of intoxication. It is only a presumption; that is, it is some evidence of intoxication which is subject to rebuttal. It is not conclusive evidence of drunkenness. It is simply some evidence to go to the jury and to be considered by the jury. That is all it is. I do not think there is any question of unconstitutionality involved.

JUDGE BYRNES: Now, this question is addressed to Dr. Guttmacher.

If youth reaction time is less than that of older persons, then what accounts for their larger percentage of accidents?

DR. GUTTMACHER: The personality make-up of youth, the heedlessness of youth, and various other factors, are the controlling factors. This only emphasizes what I should have made clear before, that the physical make-up of the individual, his reaction time, and all of these other things are relatively minor compared to his sense of responsibility.

Dr. Howard Rusk, who has made a study of paraplegics, and there are also statistics in regard to the deaf and dumb, shows that many of these people have turned out to be good drivers. It is not that serious handicaps make people better drivers, but the people who have these handicaps are so keenly aware of their deficiencies that they are extremely cautious.

It is the incautiousness of youth, which is the basic problem, and which overcomes the fact that they have speedy reaction time and quicker reflexes and all the things which should make them good drivers, but actually they are not massive enough to overcome the heedlessness and incautiousness that is so characteristic of youth.

JUDGE BYRNES: This question is addressed to Dr. Fisher.

What of the Baltimore City Medical Society Committee conferring with a legal agency re auto accidents in Baltimore?

DR. FISHER: I have done a little bit of injustice to my own profession a few minutes ago by saying that the medical society has not shown real interest in this problem.

I am reminded of the fact that the Baltimore City Medical Society this last year has had a special committee appointed to confer with the magistrates in the traffic court and the police commissioner concerning the problem of drunken driving in Baltimore. Its purpose was to meet and to review the problem of collecting and evaluating medical evidence in driving-while-drinking cases and to make firm recommendations to the chief magistrate and the police commissioner.

As of this date those recommendations have not been acted upon, and, as a matter of fact, I don't know at the moment when we may expect action.

But it is certainly true that the Baltimore City Medical Society took an active part in this problem within this year, announcing their

great concern about the drunken-driving problem in Baltimore City.

JUDGE BYRNES: This is addressed to Drs. Kinnamon and Guttmacher.

Both of you gentlemen have indicted the youth drivers. Aside from increasing the age for licensing, what are your respective solutions to their unfortunate plight?

DR. GUTTMACHER: It is in education, I would say, and the attempt is being made in the public schools. The chief traffic court magistrate, Magistrate Scherr, was also attempting to prevent the problem of the youthful driver from growing worse. We cannot prevent people from being youths. Nor can we greatly change their make-up as they go from infancy to maturity. So, when we cannot do away from this problem, it is going to be with us. It seems to me it requires education of the parents and education of the youths themselves.

Then, of course, there are age restrictions. There are some states where people are not allowed to drive until they are eighteen, and in some states they are not allowed to drive until they are twenty-one.

Whether this is desirable or not is something that I think needs study. I have no definite views about it.

Professor Farinholt, aren't there several states where the age limit is higher than here?

MR. FARINHOLT: Yes, sir, there are. The majority of the states, however, set the limit at sixteen. There are some, one or two, at seventeen, and two or three at eighteen. There is one at twenty, Nebraska. I am sorry to state that there are two at fourteen, South Carolina and Texas.

DR. KINNAMON: Judge Byrnes, could I add to that. The unfortunate plight of these teen-agers is to be seen in the accident room after they have been driving an automobile. I would rather see them walk than be in an accident room from driving.

MR. FARINHOLT: May I add a word or two?

One of the recommendations I suggested was to have a more complete physical and mental examination, including a psychiatric examination, of persons involved in moving traffic violations—persons involved in culpable accidents, or in accidents which are a reportable affair—that is, where there is injury to person or property of more than $75.00. The requirement of such an examination on these specific occasions might help weed out those teen-agers who are dangerous.

MR. ALBERT A. LEVIN: I would like to ask Professor Farinholt a question in connection with his last statement.

The burden of reporting an accident rests upon the owner of the vehicle. Suppose then a reportable accident where the owner was not even present. I gather from what you say he would also have to undergo this particular examination you speak of.

Can you tell me what would be fair about that?

MR. FARINHOLT: No, I cannot. I think that we would have to make an exception in a case of that type.

JUDGE BYRNES: Here is another question. And this question is put to Dr. Kinnamon.

Is it not clear to any reasonable person that teen-agers are more reckless than adults as drivers of motor vehicles? And should we not raise the age requirement for a driving license?

DR. KINNAMON: I would agree with that one hundred per cent. I think it would help a great deal.

JUDGE BYRNES: Here is another question addressed to Dr. Kinnamon.

Why not take a positive step forward by calling a meeting of various law enforcement agencies and other interested persons to take appropriate steps to attempt to have desirable legislation passed to try to strengthen our laws for revoking licenses for repeated reckless drivers and for other beneficial legislation?

DR. KINNAMON: Sir, I would also agree with that. But I feel it is going to have to come from the level of the governing bodies, together with

the members of the medical association. There must be some starting point for this entire program. I think with a good program, and with the appointing of various agencies to work on it, that it will come to fruition.

JUDGE BYRNES: This is addressed to Professor Farinholt.

Since speed is a prominent factor in accidents, would not the accident rate be reduced if the automobile manufacturers would limit the maximum speed of their cars to sixty miles an hour?

MR. FARINHOLT: I would like to refer that kind of question to a suitable group of experts to determine whether or not the reduction of speed by way of a governor would be effective. All that I can say from the legal standpoint would be that if it should be found that such a restriction on speed accomplished by such a device would contribute reasonably to safety, then it would be within the constitutional power of the State of Maryland to require such devices.

DR. KINNAMON: Judge Byrnes, wouldn't it be possible to enforce the present laws?

JUDGE BYRNES: Unquestionably.

DR. FISHER: I would like to add one comment to this question of speed.

Studies conducted along this line have shown that most fatal accidents, and by this I mean well over fifty per cent, occur with automobile speeds of less than sixty miles an hour. It is in the area of thirty-five to sixty miles an hour that a lot of our fatal accidents occur.

So it would appear to be a fallacy to always keep cars below sixty. To be sure, your rate of accidents is high above seventy. But not many people are fools enough to drive over seventy consistently, and it still remains true that most accidents occur between thirty-five and sixty. So I am not at all sure that speed is so important in this regard.

JUDGE BYRNES: This is addressed to you, Dr. Kinnamon.

What percentage of serious traffic accidents are on the basis of faulty vision?

DR. KINNAMON: The only report I have is the one I mentioned.

Of 31,000 accidents, there were 65 cases with defective vision. Only 2 or 3 per cent of accident cases were caused by illness, deformity and physical defects.

JUDGE BYRNES: This is addressed to any panelist who can answer it.

Has a study been made of the deterrent value of the "point system" in the revocation or suspension of licenses?

Does any panelist want to answer that?

DR. KINNAMON: Sir, I have talked to the State police about that. They heartily approve of the point system. I cannot tell you why it did not pass in the Legislature this year. I cannot tell you why some of the people in the administration of the automobile commission did not approve it. But they heartily concur with the State police that it would be useful to law enforcement in the State.

The point system is used effectively in Connecticut.

As an example, a driver in an accident, in a fatal accident, has five points against him. If he is involved in a reckless driving charge, that is three more points. The total points may be fifteen. When he reaches fifteen points, his license is automatically revoked. He knows where he stands. He knows that if he continues to break the law he will sooner or later lose his license.

As stated, it has been very effective in Connecticut, and in other states. Connecticut has one of the lowest accident rates in the country.

JUDGE BYRNES: This is the final question, to Professor Farinholt.

What is the present legal status of taking a blood sample from an accused person?

MR. FARINHOLT: The present legal status here in Maryland is that our Bouse Act would not permit the introduction of such information into evidence, and, therefore, the blood test sample cannot be introduced into evidence in a court over the defendant's objection.

I would like to refer to Dr. Fisher, to inquire as to the voluntary use of the test.

DR. FISHER: I can only say that it is in use in a number of instances on a voluntary basis.

For a long time it has been our policy in the Medical Examiner's Office in the case of a fatal accident, where the other driver was willing to have his blood sample submitted, and someone collected it, to see that it was analyzed, and a report made available to the people concerned.

It has been done on a very limited basis, in a few fatal accidents. We have *never* advocated the involuntary collection of such a sample, for obvious reasons.

JUDGE BYRNES: Thank you very much, ladies and gentlemen.

A MEMBER OF THE AUDIENCE: Mr. Chairman, if you will permit me to ask one question, it has occurred to me in the latter part of this discussion that there is one phase that has hardly been touched upon, and which to my mind would perhaps be as conducive and perhaps more conducive toward the reduction of accidents than any factor that has been mentioned here.

Now, in an occupation or a profession such as medicine, law, engineering, or anything of the sort, a test is required before the man can enter his profession.

In learning to drive, a person has either a professional driver to teach him, or he can do worse than that, he can have his wife teach him, in which case there will be an accident or perhaps a fatal one, even before he is permitted to drive. But in many of the high schools teaching students to drive is now a part of the course. It is taught in classes. I think that a course in driving, made compulsory to those intending to drive, and before they can get a license, will help a great deal in this situation.

It seems to me that driver applicants should be required to take a specific course.

JUDGE BYRNES: I think you have made a good point. I might mention that it might be a good thing to have such a course in our public schools; a course for driver education. I hope that some legislation will be passed to take care of this situation.

The meeting is adjourned.

ARTICLE OF INTEREST

AROUND THE WORLD OBSERVATIONS ON PILLS, POLITICS AND PEOPLES[1, 2]

AMOS R. KOONTZ, M.D.

I might tell you in the first place something about how this trip came about.

Last summer, I operated on a chap from Bombay, India. He asked me to come to India to open a hospital he was building and operate on some of his friends.

When he first mentioned it to me, the idea seemed so fantastic that I just thought I wouldn't do it at all. I dismissed it from my mind. Then he kept on talking about it and the idea sort of grew on me and I decided to do it. Then I wrote to several of my friends in different parts of the world and told them I was coming, and they asked me, very kindly, to make talks in various places such as Bangkok and Manila. Douglas Robb from New Zealand, whom a lot of you know, was one of them. He was here last Spring and asked me to make a talk before their Postgraduate Society in New Zealand. They had a meeting in Auckland at the time I was there, so I did that, and the trip sort of grew like Topsy. In the meantime, after all the rest was arranged, the Surgeon General of the Army asked me to go to the Far East as Surgical Consultant for the Army, and that fitted in very well on the tail end of the trip. So after I got to Japan, the Army sort of took me over, and I came home partly on their steam, but not in the same style that these Senators are going to come home or who are now just about to come home from Europe.

[1] Presented at a Special Dividend Meeting of the Baltimore City Medical Society Friday, October 21, 1955, at 5:00 p.m. in Osler Hall, 1211 Cathedral Street, Baltimore 1, Maryland.

[2] Further Observations on Pills, Politics and Peoples, by Dr. Amos R. Koontz, will be published in Volume 6, No. 11, November 1957, Maryland State Medical Journal.

I might tell you in the first place where I went. I started out from New York and I stopped only three places in Europe: London, Zurich and Vienna; then to Istanbul, Beirut, Jerusalem, Bethlehem, Damascus, Baalbek, Baghdad, Babylon, Teheran, Karachi and India. I was in Bombay, Delhi, Ambala City, Agra, Benares and Calcutta in India. Then to Bangkok, then down to Singapore; to Indonesia—Java and Bali; then down to Australia and New Zealand, and Fiji once again where George Finney and Adam Bock, sitting back there, and myself fought a few battles back in 1942. Then to Manila, Hong Kong, Japan, Korea, Okinawa, Hawaii, San Francisco and home.

I have been very much interested in Asiatic history in the last couple years and during the year before I went over there I read a lot of Asiatic history as a sort of preparation for this trip, and among the things I read were the Lives of Genghis Khan, Tamerlane, Kublai Khan and of that fabulous "gal," Nur Mahai, who was the favorite wife of Jahangir, the fourth Mogul Emperor in India. She not only controlled all the intrigues of the Harem but also controlled the Emperor pretty well. Her niece, by the way, was Taj Mahal for whom the Taj Mahal was built. Taj Mahal was the favorite wife of Shah Jehan, the son of Jahangir. Nur Mahal means "Light of the Palace," and Taj Mahal means "Crown of the Palace." Taj Mahal was also called Muntaz Mahal, which meant "Jewel of the Palace," and they certainly have built a jewel of a memorial to her, because, it is said that the Taj Mahal is the most beautiful building in the world, and I believe it is. It is of perfectly lovely

soft white marble and is the most beautiful thing I have ever seen in an architectural way; really a poem, a symphony in stone.

Then among the other things I read preparatory to this trip, an accessory to it, were the Lives of such people as Omar Khayyam; Suleiman the Magnificent of Turkey; Ivan the Terrible; Peter the Great, who was a great big tall giant of an Asiatic who tried to make Russia a European country without success because he was the laughing stock of every Court he went to in Europe. Then, Catherine the Great, who was a German Princess as you know, who became the Empress of Russia. She married the Czar, Peter III when he was Crown Prince, and when he became the Czar it is said that she had him killed so she would become the Empress, which is probably true. At any rate she was quite a "gal" and she had one romance after the other amounting up to twenty some, from the time she was a young girl till the time she died at the age of 65.

Then there was also one of the things I read that was most fascinating—Spengler's "Decline of the West," and I think everybody who is interested in what is going on in this world today, ought to read it. He shows what became of the civilizations in the effete East and our civilization is apt to become just as effete if we keep on the way we are going.

I want to just say one word about Vienna because I got a little light on the Russians there. Maybe some of you all remember an Austrian, a delightful chap, who spent a year in Pathology at Hopkins years ago, named Gustav Riehl, now Professor of Dermatology in Vienna, and his father before him was also Professor there. A bust of his father was recently unveiled at the University.

I had dinner with him one night and he told me that the Russians had occupied his country place, and that during the time they occupied it they used his bathtub as a latrine and filled it right to the top. They used the toilet bowl to wash their heads in and to cool their milk in. He said that was habitual with them. Also on one occasion a Russian saw an alarm clock which went off and the Russian had never seen an alarm clock before, so he shot it. Dr. Riehl said he had had ten years experience with the Russians. The Austrians have been living under their occupation that long, and he said that they are very dangerous people because they react violently to simple things that they don't understand, and which makes them extremely dangerous.

Then I went on to Istanbul, which I was so glad to see. By the way, among the reading that I did before going, was the full history of the Crusades, which was most interesting, and in which Constantinople played a great part. I was very much interested in seeing places in Istanbul which I had always read about in history, such places as the Golden Horn, Sublime Port and many other interesting places.

One of the most interesting things about Turkey is the fact that it has been completely Westernized by the late Kemal Ataturk. When Kemal Ataturk took it over, it was an Eastern country completely, and now it has been almost completely westernized. One thing Kemal Ataturk did was to make everybody take a surname. Nobody had a surname in Turkey till he came along and you can imagine how confusing it was if you wanted to call up your friend Tom, and found ten thousand Toms in the telephone book. So he took a surname himself. His name was Kemal; he took Ataturk as surname, and made everybody else take one. He introduced coeducation; he introduced civil marriages; he abolished polygamy. Whether that is good or not is debatable. He abolished veils for the Moslem women and fezzes for the men. He also introduced the Latin alphabet in place of the Arabic alphabet, which makes their stuff look like you can read it, whether you can or not.

Beirut is one of the most interesting cities in Asia I think, and one of the most progressive cities; a perfectly lovely city and the standard of living is very high there. The most remarkable

institution in Asia is the American University in Beirut, which is a missionary university founded by the Presbyterians at the time of our Civil War. It is now entirely nonsectarian. They have forty different nationalities there and twenty-seven different religions. Four thousand students; there are all departments of a university—Liberal Arts, Law, Medicine, Engineering, and Agriculture which is very important there, and all other departments of a university. It has had a magnificent influence on all those Middle Eastern countries because graduates of that university are in the Cabinets of all the Middle Eastern countries, and some are Prime Ministers. There are also other high government officials in those countries from American University.

I went to see the Professor of Surgery there, who is a Harvard man about forty years old, I'd say. He had been there just two years. He graduated from Harvard and had his training at Massachusetts General. Then he practiced in San Francisco for some years and was on the Surgical Staff at Stanford with Emile Holman. He is a very interesting chap. They have two services, one headed by the Professor and the other by a Lebanese. The Faculty of the American University are part American and part Lebanese. The Lebanese Surgeon I saw work was excellent, and a very interesting chap to talk to. He told me about some of the remarkable fees he gets. He said that a couple of years ago he operated on the Crown Prince of Saudi Arabia, who is now the King, and that the last time he visited the Crown Prince in the hospital before his discharge the Prince turned to his Secretary and said: "Send the doctor a car." So a Cadillac came around almost immediately—this besides an enormous fee. Just two days before I was there, he said that somebody handed him a couple keys. He went downstairs and there was a Cadillac in front of the door to fit the keys—something that has never happened to me and I don't know how many of you all it has happened to.

The type of surgery they get from Beirut is almost the same type we get here, but the type of surgery they get from outside of Beirut and the rest of Lebanon is entirely different. They get all sorts of things that we don't see here at all, including hydatid disease. I had seen a lot of this in New Zealand and South America, but I hadn't realized they had it over there. Also Beirut is a very interesting city from the point of view of the various costumes one sees. You see every costume in the world there. Eastern, Western—all sorts of Eastern costumes, turbans of all sorts, East Indians, Kurds, Afghans, Egyptians, fezzes of all sorts, some women are still in what they call "purdah" because they have to wear veils, but most of them are not, they have gotten free from that principally. Some women wear just a veil that leaves their eyes exposed, some of them have complete veils with just a couple of holes for the eyes, and some of them will wear a veil and bring it across so that just one eye is exposed, they only will risk one eye, I reckon, but it is very interesting from that point of view.

That part of the world is also very interesting from the point of view of the various breeds you see there, and also the various kinds of half breeds. I was sitting in the Bristol Hotel at Beirut at dinner one night, and saw an exotic, beautiful-looking girl at another table. I inquired about her and found she was half French and half Arabian, a very unusual combination and a very pretty combination. You see all sorts of combinations both in Asia and the Pacific Islands, and one of the commonest combinations is Chinese mixed with various other races. One of the most beautiful combinations I saw, and we saw there during the war, were Chinese and Polynesian mixtures. You remember them, George and Adam, very pretty girls, and I remember also. I personally have never seen what I considered a pretty, full-blooded Polynesian, but I have seen a lot of pretty half-caste Polynesians. In the civil hospital in Fiji during the war, remember George, that there was a beautiful telephone operator? You wouldn't re-

member her, would you? She had a beautiful face and beautiful figure—half Polynesian and half Caucasian. I had been made honorary member of the Defense Club in Suva, which would sort of correspond to the Maryland Club here in a small way, and I spoke to one of the characters in the Defense Club one day about the telephone operator. He knew all about her and when I spoke of her he said "Oh yes!—you know, necessity is the mother of invention and the father of half-casts!"

Well, I just want to say a few words about Jerusalem because everybody is interested in Jerusalem. All of the old historic part of Jerusalem is in Jordan, not in Israel. I was surprised to find that out, and I didn't go to Israel at all, because I found in getting the visas for these countries that if I got a visa for Israel that none of the other Middle Eastern countries would let me go there, so I couldn't go to Israel. I had a choice of going to Israel and none of the rest of the Middle Eastern countries or vice versa, so I chose to go to the rest of them and leave Israel out. The place I was interested in going to especially was the old part of Jerusalem, and in the old part of Jerusalem there are a lot of interesting places, a lot of interesting Mosques and interesting Christian Churches of all sorts, Greek Churches, Roman Catholic Churches, Protestant Churches, Syrian Churches, Armenian Churches, all sorts of churches, but outside of these historic religious places I didn't see a single habitation that I thought was hardly fit to live in in Jerusalem. The people live in little holes in the wall. I didn't see a good house in Jerusalem. If there were any, they escaped my notice, except for these religious places. They apparently think a lot about the hereafter but not much about the present.

Bethlehem is in about the same situation and I couldn't help thinking of, when I was in Bethlehem, and sympathizing with, a British soldier who was stationed there during World War I, and who wrote home to his family and said "Here I am in Bethlehem where Christ was born and I wish to Christ I was in Nottingham where I was born."

The country is very desolate. It is desert country. You find a little oasis occasionally where you can raise a little crop but the country is very desolate.

I haven't time to talk about Baalbek where there are a lot of Roman ruins which excel anything I have seen in Greece or Rome. The biggest place of worship of any sort ever built is the Roman Temple of Jupiter there. It is in ruins now but is a perfectly magnificent thing which defies description, and so I will just pass on and not try to describe it.

Damascus is a very interesting city, much more modern. It is the second most modern city I saw in the Middle East. Beirut is the most modern and Damascus is second. A lot of fine houses, fine buildings, and a lot of places of historical interest. It is situated in a little oasis with desert all around it.

Baghdad, I think is the dirtiest place I have ever been in, with the possible exception of Egypt. I stayed in Baghdad at the Tigris Palace, but the only way that the place resembles its name is the fact that it is located on the Tigris River. Otherwise you wouldn't think it was any palace because it is a very dilapidated old hotel, although it is one of the best hotels in Baghdad. I asked for a barber, they had no barbershop, but sent me down the street to a barber who happened to be a very nice, clean barber who spoke English very well. I found out that he had a nephew who is a doctor in Chicago and who is an American citizen.

Another little touch of Baltimore I found in one of their hospitals, too. I went to their principal hospital and found that the operation that is most commonly performed in the hospitals in Baghdad is the operation for kidney stones. Their climate is so dry that no matter how much water you drink it just comes out through your skin, and the urinary salts are concentrated in the kidneys and form a lot of stones. There they were taking out staghorn kidney stones by the

bushel, Goldie, and it would have been a field day for you; you ought to go, you and Howard.

There I also saw a young plastic surgeon who was doing perfectly beautiful work. I asked him where he got his training and he said at the Franklin Square Hospital in Baltimore. He was trained by Herb Wilgis, who is the Chief of Surgery there, and Herb Wilgis as you all know, has a flair for plastic surgery and did a lot of plastic surgery with Dr. Staige Davis years ago. So this youngster, Dr. Omari, was doing perfectly beautiful plastic surgery, and one of the things he had most to operate on were noses. Some of these noses had been demolished by what they call Baghdad Boil, which is a form of leishmaniasis that destroys their noses, and then they have to have something done about it. Rodent ulcer also takes its toll. But a lot of these noses were the noses of women which had been cut off by their husbands, It seems that if a man in Baghdad surmises that his wife has been unfaithful, whether that surmise is based on fact or fancy, the gentle Baghdadian simply cuts off her nose and then this young plastic surgeon, recently from Baltimore, has to fix it up.

All this Middle Eastern country, as I said, is desert country, and when you fly, you fly for hours with nothing but desert under you. There are also huge mountains that go up to 14,000 feet, some of them with snow on the top, but just as bare as they can possibly be, perfectly desert mountains.

Babylon is nothing but excavations. The foundations of the old places are there and nothing else.

Teheran is situated in an oasis and is a very interesting city, far ahead of Baghdad. I went to one of their hospitals; there was very little going on. They don't do much surgery in the summer time, they said. I don't know why but anyway there was very little going on in the hospital the day I was there, except that I saw some people who were very anxious to come to Baltimore to get training. They especially spoke of Hopkins and the Baltimore City Hospitals. We have had a lot of people from Teheran come to the Baltimore City Hospitals, and one of them was Resident in Surgery last year and was a very excellent man indeed.

One thing that strikes you in all Asia is the great number of refugees every place. The Middle East is full of refugees. All the Middle Eastern countries are full of Arab refugees from Israel. Pakistan is full of Moslem refugees from India; India is full of Hindu refugees from Pakistan; Hong Kong is full of refugees from Red China, and South Korea is full of refugees from North Korea. All these refugees live under perfectly miserable conditions, some of them under just a little tent flap (of course the country is dry, that is one thing, it helps), or in miserable wooden shacks and some of them have small tents. In Hong Kong the sidewalks are rather broad, and they live under lean-to's on the sidewalk. They have half the sidewalk as their home with a little lean-to to protect them. Then the city has built latrines in the middle of the street which they use, but in most places the refugees have no latrines at all. They simply use the desert, the bush or anything they can get to.

Now I'd like to talk about India a little bit. India, I think, is the most amazing country I've ever been in. I did twelve operations in India, and those operations were done in three different hospitals. I did only three operations on private patients there. They have the British system and my private patients were operated on in a nursing home, which is a small private hospital, but which was very good. Then I operated in a public Hospital the King Edward Hospital, and also in a Mission Hospital up in the Punjab, 125 miles north of Delhi. I have heard from all my patients since I left. They all got along alright, which is some satisfaction.

In the public hospital, the King Edward hospital in Bombay, they showed me a case of scrotal hernia. He had a scrotal mass which was reducible and which had all the earmarks of a hernia. I started to operate on him and opened the cord to find the sac. A lot of milky fluid ran

out. He had filariasis, so I inadvertently operated on a case of filariasis. I did a La Roque incision above the internal ring, put my finger on the inside and found he had no hernia at all, neither direct nor indirect, nor femoral. They had never seen a La Roque incision before or even heard of it, so they were glad to see that at any rate, and I was glad to see what the inside of a case of filariasis looked like. Most of the cases I operated on were big hernias, some were huge scrotal hernias, some were huge ventral hernias. They wanted to see the tantalum mesh technique demonstrated.

One other case I operated on was a boy thirteen years old who had become obstructed, and his obstructing lesions—he had five obstructing lesions—were tuberculosis of the cecum and four tuberculosis lesions in the terminal ileum. I simply did a side-tracking operation, anastomosed his ileum to his transverse colon. We don't see intestinal tuberculosis here. I haven't seen a case for twenty-five years. I don't know how often you all have, but we used to see an occasional case of tuberculosis of the cecum. Have you seen one recently, George? I would have resected in this case, but the people there who see this thing all the time told me not to resect, that with the new anti-tuberculosis drugs, he'd get well. I hope he does. Anyway, he was alright when I left and when I heard from people over there recently he was still alright.

In the mission hospital up in the Punjab I operated on a lot of queer characters. One was a Hindu priest, not that the priest was a queer character, but it was a little unusual for me to operate on a Hindu priest. I also operated on an old Sikh, 59 years old. Yon know they don't cut their whiskers or their hair. They wear a little top knot on top of the head. They have a religion all their own; it is neither Moslem, Buddhism nor Hinduism. This Sikh was a crusty old fellow and he had two wives. One was young and pretty and she was around the hospital all the time. He kept the other one hid. I understand she wasn't so pretty.

The Indian patient I operated on over here in August 1954 was a Parsee. Parsee is a corruption of Persian, and Parsees are Persians who left Persia twelve hundred years ago, when Persia became Moslem, and went down to India in order to escape religious persecution, because they wanted to keep their religion, which was Zoroasterism. They still have kept it. They do not intermarry with other people, and are a little close community. There are about 250 thousand of them in the world, and 50 thousand of them are in India. They haven't taken sides with either the Moslems or the Hindus in India and therefore they haven't made enemies, but they have made a lot of money and they are prosperous as a result of neutrality.

There are three types of disposal of the dead in India. The Moslems almost invariably bury their dead. The Hindus do invariably cremate theirs. The Zoroasters take theirs up to a Tower of Silence. This is generally concealed in a grove of woods some place. The pallbearers and the Priest go up to the top of the tower with the body. After the last rites are performed, they take the clothes off the deceased and leave him there naked. In about a half an hour the vultures have picked the bones clean, then the bones are put into some sort of vat to dissolve, after which the remnants are slipped down a chute into the river, and go on out into the sea, and that is the end of that.

Now a lot of people have asked me about Communism in India. I don't think the Indians have the faintest conception of what Communism is like. I don't think they know anything about it. I have never seen people who have as little contact with reality as the Indians have. They have produced two of the most mystic religions in the world, Buddhism and Hinduism, and those mystic religions continue to react on them to keep them mystic and make them more and more mystic. Their idea of non-resistance is just incomprehensible to me. I can't understand why anybody would want to be non-resistant about anything that was going to be harmful to

them. I don't think they favor Communism, but are oblivious to its dangers. All they want to do is to get along the best they can. They don't get along very well anyway, and feel that nothing could be much worse than what they have.

I think we have some leaders in this country, too, who are pretty naive with regard to Communism. I don't believe we can deal with the Communists as a lot of people in this country think *they* can. Lenin, way back in 1903 said that Communism was going to gain world supremacy by fair means or foul, by murder, cheating, lying, stealing, and breaking international contracts. As far as I have been able to make out, they have never deviated from that plan at all. They have said also that one of their maxims is "One step backward and two steps forward." When you see the Communists smiling and agreeing with you, you better make sure they are not taking that one step backward with two steps forward in the offing.

Now, they have a democracy in India. I don't think they are any more fit for democracy than I am to be the Angel Gabriel. I'm a little bit removed from that. One American woman told me she was in a village the first time they voted for any candidates. There were two candidates for Congress. They didn't know whom to vote for, so these Indians went to the Hindu Temple, put down a few coins (which I have seen them do many times), threw some incense on the fire, said a few words, and something turned out that made them think they ought to vote for one particular candidate, so everybody in that village voted for that candidate.

Now that doesn't seem to me a very practical working democracy. I am sure they are not ready for it and I wonder sometimes if we are with some of the candidates we elect. The same thing is true of Indonesia. Indonesians are lovely people; everybody likes the Indonesians, those who have been there. I didn't see anybody in Indonesia who didn't like them. My wife and son spent a winter in Indonesia—Java and Bali—and they thought they were lovely people. But they don't know anything about democracy. Just recently they voted for some "red" thing without knowing I am sure what it is all about. The UN turned these countries loose on their own without any training whatsoever. We trained the Filipinos fifty years before we turned them loose, and they are doing a pretty good job in the Philippines.

These people would take a lot more time than that before they were ever ready for democracy.

(*Continued in November 1957 Maryland State Medical Journal*)

1014 St. Paul Street
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Report

COMMITTEE FOR THE STUDY OF PELVIC CANCER*

BEVERLEY C. COMPTON, M.D., *Secretary*

The Committee for the Study of Pelvic Cancer meets monthly, October–June, for the discussion of selected cases. All physicians are cordially invited to attend these meetings.

Abstracts of Case Discussions

A forty-five-year-old white patient, married, gravida 5. Early in 1955, the patient first noted post-coital bleeding. The menses at this time were said to be normal. She consulted doctor A in early February, at which time a pelvic examination was made and the patient was told that she had a "small ulcer on the womb." She was given some medication for this. The patient says that the symptoms cleared up and that she had no further trouble until August 1956 when she began to have slight intermenstrual spotting and post-coital bleeding. She did not consult a physician until December 1956, when she again saw doctor A and was told that the irregular bleeding was probably due to "the beginning change of life." In late February 1957, she was referred to doctor B. A pelvic examination was made and a biopsy taken which revealed carcinoma. The patient was referred for treatment and admitted to the hospital in early March.

Diagnosis: Carcinoma of the cervix, international classification stage II.

Treatment: Radium and deep x-ray therapy.

Chairman: Does anyone wish to say anything concerning this case?

Visiting Surgeon: This patient was referred to us for treatment. The diagnosis was made at another hospital and then the patient referred to us. She has been treated and has responded very well to routine therapy. There was nothing unusual about the case except the delay in establishing the diagnosis.

Chairman: When this patient first had post-coital bleeding in early 1955, she apparently consulted a physician without loss of time. The physician did make a pelvic examination. In reviewing cases, as we have done over the past several years, it is surprising how often this is not done. The doctor does not do a pelvic because the patient is bleeding or for some other reason. There seems to be a wide-spread feeling that a patient should not be examined when she is bleeding. Of course, we feel that she should be examined. It is often helpful to be able to see where the bleeding is coming from.

In this case, following examination, the patient was told that she had a "small ulcer of the womb." The term "ulcer" is often used loosely. If this was a real ulcer, that is a lesion showing real loss of tissue, it was possibly carcinoma and a biopsy was indicated at this time. Unfortunately we do not have any further information from the physician as to his findings.

Committee Member: The story is rather unusual. The patient complained of post-coital bleeding and examination showed an "ulcer." Following whatever medication was used, the bleeding cleared up and the patient had no further trouble for eighteen months or more. Don't you think there is question as to whether the small ulcer noted on the first examination was carcinoma?

Chairman: Yes, I think it is an unusual story, but I think it is quite possible that carcinoma was present in early 1955. Some carcinomas de-

* Under the auspices of the Medical and Chirurgical Faculty and the American Cancer Society, Maryland Division.

velop very slowly. Carcinoma-in-situ can lie dormant for a long time.

Almost all carcinomas of the cervix at the time they start to bleed are curable. Of course, you will occasionally see a patient who has had absolutely no symptoms until a sudden severe hemorrhage and you find that she has a stage four cancinoma of the cervix. But this is very rare.

My feeling in regard to this case under discussion is that with a history of post-coital bleeding and a so-called "ulcer" on the cervix, further investigation was indicated. Post-coital bleeding is a very important symptom. It is amazing how often this is the first symptom in carcinoma of the cervix.

Visiting Physician: I am not a gynecologist. I am an internist and I do not know about these things. Do you believe that this physician could have been criticized in 1955?

Chairman: The internists are often the first to see these patients and the promptness of establishing a diagnosis often depends on them.

To answer your question, with a history of post-coital bleeding and an "ulcer" on the cervix, I think the patient should have had a biopsy or at least a Papanicolaou smear. I think the Committee will agree with me on this.

Visiting Physician: I do not think it was so much the failure of the attending physician as that techniques have changed since early 1955.

Chairman: Well, cytology was available then and certainly biopsies were being done fairly routinely.

Committee Member: I think it is quite true that we are all more conscious of carcinoma now than even two or three years ago.

Visiting Physician: There may have been some delay, but I do not believe that we can judge too harshly. If this was carcinoma at the time of the symptoms in early 1955, don't you think she would have had further symptoms before August or September of 1956? Perhaps this was just a chronic cervicitis that cleared up with treatment?

Chairman: It is possible. I still think that it is more probable that there was something there other than a chronic cervicitis.

Visiting Surgeon: There was certainly delay between December 1956, and February 1957. At this time the patient was having intermenstrual bleeding and post-coital bleeding and, according to her story, she was told that these symptoms were due to "beginning change of life."

Committee Member: There was some patient delay at this time, too, but I do not believe we can put too much responsibility on the patient. She had probably received a false sense of security following her visit to the doctor for previous similar symptoms.

Visiting Physician: I sometimes find it quite difficult to have a woman submit to a "cancer examination" on her first visit. To take a biopsy or even do a smear requires some explanation and many patients become apprehensive or really alarmed that they may have cancer. I sometimes find it better to have them return for a second or a third visit to try to gain rapport with the patient.

Chairman: I, of course, do not meet that problem. If a patient comes to a gynecologist, she expects such an examination. People are unquestionably becoming more cancer conscious. If you do a pelvic as a routine part of an examination, I do not think it would alarm the patient.

Committee Member: I think it can work the other way, too. With the increasing knowledge in regard to cancer, a patient may feel she has symptoms which indicate a biopsy and is worried if this is not done.

Visiting Physician: If a patient gives you a lead that she is worried about cancer, there is, of course, no problem about making whatever examination is necessary.

Chairman: If you feel it is better psychologically to get the patient in the mood, all right, but be sure she does come back. Too often we hear the story of a patient who is advised to return for further examination but for one reason or another she does not get back until she has an advanced lesion.

Visiting Physician: What do you think are the indications for a smear as opposed to a biopsy?

Chairman: If there is a "target lesion," a biopsy should be done. If there is nothing suspicious, I would do a smear. A smear is a screening process. It picks out the cases which require biopsy. If a smear is reported as positive, a biopsy should be done.

Case 2. The patient was 43 years of age, colored, married gravida 0. In 1948, she had a total abdominal hysterectomy for myoma. She had been followed in the breast clinic since 1950 regarding chronic cystic mastitis. When seen in this clinic in August 1956, she complained of severe pain with bowel movements and nagging pain in lower abdomen for several weeks, and was referred to the G.I. clinic for study. Various diagnostic studies were made. It was noted that a proctoscope could not be passed beyond the recto-sigmoid junction which was thought due to hypertonicity of the sigmoid as demonstrated in the barium enema. G. I. x-rays noted the possibility of extrinsic pressure in the pelvis. The patient was put on phenoba bital and belladonna and discharged from this clinic in late August. She says that the abdominal pain increased and became "stabbing" in character. Because of this she consulted her family physician in early October and was referred back to the hospital regarding "possible kidney stone." She was seen in the gynecological clinic on October 10th, and admitted to the hospital.

Diagnosis: Serous papillary cystadenocarcinoma of the ovary, bilateral; carcinomatosis with liver metastasis.

Treatment: Bilateral salpingo-oophorectomy; partial omenectomy. Colloidial gold, 150 mc., October 25th.

Chairman: Does anyone have anything to say concerning this case?

Guest Surgeon: I am sorry to say it but this seems to be a case of delay on the part of the hospital. The history is as given. The possibility of an abdominal mass was suggested in the x-ray reports but the patient was not referred for pelvic examination and got back to us only because her family physician saw her and sent her back. Unfortunately the case was too far advanced anyway for anything to be done. The whole pelvis was filled with carcinomatosis. The patient died within six months.

Chairman: As is so often the case with ovarian carcinoma, the carcinoma is far advanced before the patient has symptoms. I am sure the outcome would have been the same had the patient been referred to the gynecological clinic, as she should have been, in August. We gynecologists feel that any woman with vague abdominal pain should have a pelvic examination.

Visiting Surgeon: I am wondering why both ovaries were left in at the time of hysterectomy?

Chairman: The surgery was done in 1948 when the patient was only 32 years of age. She was a comparatively young woman. If the ovaries appeared to be normal, I don't think we can criticize the surgeon for leaving them in.

Visiting Surgeon: By the time you saw this patient in the clinic, she had far-advanced carcinoma. Why operate at all?

Chairman: Even though you are reasonably sure of the diagnosis of carcinoma, ovarian tumors will occasionally fool you. The so-called Meigs syndrome with abdominal fluid is most often due to a fibroma of the ovary and is benign. Other cases with implants over the peritoneum, will occasionally regress after the primary tumor is removed. And very rarely you will get a papillary cystadenoma of the ovary which is grossly malignant, but microscopically benign. This is rare but it does happen.

For these reasons I think it is important to open the abdomen.

Visiting Surgeon: I recall one very interesting case followed in our clinic. On examination the patient had a large cystic mass. An exploratory laparotomy was done and the patient found to have a papillary carcinoma of the ovary with extensive involvement of all the abdominal organs. We decided to do nothing surgically at this time but to treat her with intensive deep x-ray

therapy. Following this therapy there was marked regression in the size of the tumor and some months later she had a pan-hysterectomy and bilateral salpingo-oophorectomy. She is living and well today—almost six years later.

Visiting Surgeon: In this case we are discussing, would a culdoscopic examination have shown anything?

Committee Member: No, the pelvis was solid with tumor. The cul de sac has to be free for culdoscopic examination.

Committee Vote: Institutional delay.

Case 3. The patient was 33 years of age, married, gravida 4 0 0 4. She gives a history of normal periods to June or July 1956, when she began to have profuse bleeding with passage of clots at the time of her periods. She consulted doctor A in July. A pelvic examination was made and the patient understood that the examination was negative. In October, she had two episodes of profuse bleeding with clots. In late November, she consulted doctor B. A pelvic examination was made and following speculum examination there was profuse bleeding which continued for several days. She was told that she had an infection due to trichomonads and that she might need a D. & C. because of the excessive bleeding. On December 5th, there was another episode of very profuse bleeding and the patient was brought to the hospital accident room. She was admitted to the hospital on the obstetrical service—pregnancy was estimated at about thirty weeks. (The patient had not known prior to this time that she was pregnant. She gave a history of regular periods through three previous pregnancies.) Following admission to the hospital, she had several episodes of very profuse bleeding. It was thought that she had a carcinoma of the cervix but this could not be established by biopsy until December 15th. The diagnosis was carcinoma of the cervix, stage I. The patient had radium application (2400 mgm. hours) on December 19th, and a second application (2400 mgm. hours) on January 2nd. On January 9th, cesarean section was done. Deep x-ray therapy was started on January 16th.

Committee Member: This was our case and a very interesting one. The patient had a big fungating lesion. The boys on the obstetrical service had great trouble in examining the patient. Every time they tried there was so much bleeding that they had to stop. They suspected carcinoma but it was some time after the patient was admitted before they could get a biopsy and prove the diagnosis. We estimated the pregnancy at about thirty weeks when we first saw the patient. It is our policy to treat these patients as nearly routinely as possible. We gave the usual two applications of radium before the baby was delivered by cesarean. Even after radium, this patient had such a big thick cervical lip that we have since excised this, using the electro-surgical technique. She has done very well now. I think we have probably cured her.

Visiting Surgeon: Was the baby apparently normal?

Committee Member: Yes, the baby was apparently all right.

Visiting Surgeon: Was the baby male or female and how much did it weigh?

Committee Member: It weighed 1520 gm. according to this record. I quote from the record: "a live, apparently normal, 1520 gm. premature infant." I think it was male, though I don't seem to see that in the record at the moment.

Visiting Surgeon: Could you use the radium in the regular way—in a Brack plaque and tandem?

Committee Member: Yes, but actually because of the big thick lesion we could not get too far up into the cervical canal.

We did have some discussion in this case as to whether we would do the cesarean before we gave the second radium. Then it turned out there was a breech presentation and that ended the argument. The lesion was so thick anyway that I was sure the radium could not get very near the baby.

Committee Member: I don't go along with your reasoning as far as the breech presentation is

concerned. I would think that a baby in normal position was a better reason for not worrying than in a breech presentation.

Committee Member: Well, actually I think this lesion was so thick and the radium so far away that there was not much reason to worry anyway. It is pretty well established that you do not damage the child after the fifth month as far as the head is concerned. I think the literature pretty well substantiates this.

Committee Member: Yes, but with a child in breech presentation, what about the danger to the reproductive organs?

Visiting Surgeon: May I ask one question? If the baby is viable, would you consider going ahead with x-ray?

Committee Member: No, I would empty the uterus first. Our policy, in general, in treating carcinoma of the cervix during pregnancy is to stick as closely as possible to our regular routine. If the pregnancy is in the fourth month (or earlier) we do a hysterotomy between the first and second radium applications.

In this particular case, as I have said, the patient had a big fungating lesion. If she had not been pregnant, we would have excised this lesion at the time of the first radium. But she was having so much bleeding at that time that we were afraid to do this.

Committee Member: I think it is very important to treat these cases as nearly routinely as possible, regardless of the pregnancy. The patients who seem to do the worst are those in whom pregnancy is interrupted. I think there is good reason for this. It is well known that to get a good radiation result you must have a good blood supply. Radiation in involuting tissue is not as effective as it would otherwise be. Radiation before the circulation involutes gives the best chance for a good result.

Chairman: I agree entirely that carcinoma of the cervix in pregnancy should be fully treated. This has not always been the case. Some years ago, Dr. Burnam, for instance, would give a little radium—allow the pregnancy to continue—and then perhaps give more treatment following delivery. Are you familiar with those results?

Committee Member: Yes. As a matter of fact it was while I was with Dr. Burnam that I saw a good many of these cases. I would not agree that he undertreated a patient because of pregnancy. It was often the same treatment as in non-pregnant cases. It was undertreatment by today's standards. We were not using routine x-ray in those days. My impression from a study of these cases was that there were unhappy results in treating involuting tissues. And patients treated at term did poorly. After the fifth month, patients treated with radium could hope for a viable child. Under the fifth month there was danger of an anencephalic child. The fifth month seemed to be the critical time for carrying the baby. I remember one patient who was treated during two pregnancies. She was treated and delivered. By the time she got back for further treatment she was three months pregnant again, and was treated a second time.

Chairman: To get back to the case under discussion, how should we classify this case?

Committee Member: The patient was pregnant and also the carcinoma must have been present at the time she consulted the first doctor in July. The patient understood this examination was negative. I would think this would mean doctor delay.

Chairman: Do we have any further information from this doctor?

Secretary: No. We have a letter from doctor B, but nothing from this first physician.

Committee Member: The patient reports profuse bleeding at the time of the examination by doctor B. He apparently still missed the diagnosis but the patient was seen in the hospital shortly after this. I don't quite understand why the pregnancy was not known until the patient was seen in the hospital.

Committee Member: She gave a history of

regular periods through three previous pregnancies.

Chairman: Are we agreed that there was loss of time in establishing the diagnosis?

Committee Vote: Physician delay.

Carcinoma of the cervix with pregnancy as a factor—incidence of occurrence in 1036 cases; 52 cases as follows.

14 cases diagnosed and treated during pregnancy.

1 case—stage III
3 cases—stage II
9 cases—stage I
1 case—stage 0

2 additional cases carcinoma-in-situ, known during pregnancy—delivered normally—treated following delivery.

6 cases biopsied and diagnosed at time of delivery.

1 case—stage III
1 case—stage II
4 cases—stage I

18 cases diagnosed during post-partum follow.

1 case—stage III
2 cases—stage II
7 cases—stage I
8 cases—stage 0

10 cases diagnosed at time of D. & C. following incomplete abortion.

4 cases—stage I
6 cases—stage 0

2 cases with positive smears during pregnancy, diagnosed and treated following delivery —stage 0.

SPECIAL MEETING OF THE SECTION ON INTERNAL MEDICINE

of the Baltimore City Medical Society

John Eager Howard, M.D., Chairman Katherine H. Borkovich, M.D., Secretary

Friday, November 15, 1957, 8:15 P.M.

Osler Hall, 1211 Cathedral St.

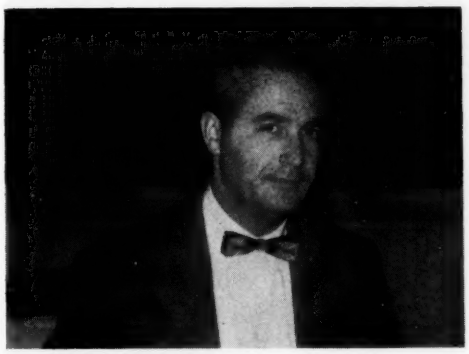
Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

Dr. Rothstein Addresses Nurse's Association



Dr. Martin Rothstein

Dr. Martin Rothstein, Frostburg, Maryland, addressed the Maryland State Nurse's Association convening in Cumberland at the Shrine Country Club.

Dr. Rothstein's subject was the Effect, Symptoms and Treatment of Atomic Radiation. He is Medical Director of Casualty Clearing Station, No. 5, for Civil Defense in Allegany County.

Dr. Rothstein is president of the Staff of Miners Hospital in Frostburg and is on the Medical Staff of Sacred Heart Hospital in Cumberland.

Personals

Reserve Captain, Dr. Richard J. Williams has returned from a two weeks training program at the Naval Aviation Center, Pensacola, Florida. Dr. Williams is a specialist in Cardiology and Internal Medicine in Cumberland.

Dr. Ralph Roth, of Cumberland, has completed his training at Johns Hopkins Hospital in Radiology and was associated with Drs. Cawley and Rathbone during the summer months. Later he will attend lectures in London, England, to further his medical training, on a scholarship of the American Cancer Society.

Dr. Leslie Miles, Jr., Lonaconing, has recently been attending Clinics at Mercy Hospital, Baltimore; furthering his studies in Cardiology.

Dr. Adolph Wolferman, is now located at 36 Green Street, in Cumberland. His practice is limited to Otolaryngology. He was born in Hamburg, Germany and came to the United States in 1946. After graduating from Geneva University, Switzerland and serving his internship at Maryland T. B. Hospital, he first located at Frostburg, doing general practice for five years. He then served a residency at the Baltimore Eye and Ear Hospital for two years and spent a year at Ohio State University, Columbus, Ohio; after which he was located in Toledo, Ohio. On October 15, 1956, Dr. Wolferman opened an office in Cumberland. He has a wife and three children.

In Memorium

Dr. J. Kile Cowherd, one of Cumberland's leading physicians for many years, and a graduate of the Medical College of Virginia, died after a long illness. He delivered "Bobby Williams," famous Notre Dame football player on the All American League.

Dr. Cowherd was 71 and a member of the Staffs of Sacred Heart and Memorial Hospitals, in Cumberland.

Civil Defense Unit Needs Volunteers

The medical profession plays an important role in the Allegany County Civil Defense organization.

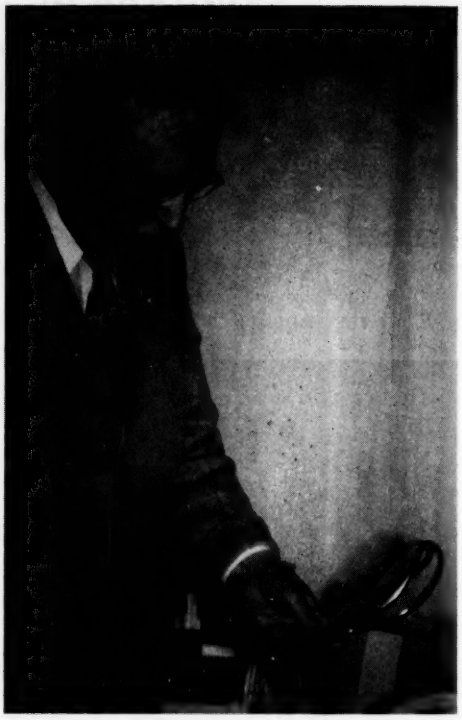
The medical effort is directed at organizing and training of six casualty clearing stations. These consist of professional medical personnel such as doctors, dentists, pharmacists and nurses. In addition, because the needs of an emergency will require that the trained medical personnel be spread rather thin, volunteers are needed to undertake training to fill less technical but vital spots.

Cumberland has been allocated four of the six casualty clearing stations designated by the Maryland Civil Defense Agency for Allegany County. The following are chiefs of the casualty clearing

stations for Cumberland; No. 1, Dr. G. Overton Himmelwright, No. 2, Dr. Clay Durrett, No. 3, Dr. Leland Ransom, No. 4, Dr. James G. Stegmaier. Dr. Martin M. Rothstein is chief of Station No. 5, in Frostburg and Dr. P. R. Wilson, is chief of Station, No. 6, in Westernport.

During the past winter the nucleus of Casualty Stations 1 and 2 received intensive Red Cross first aid training and are undergoing more detailed operational training under the leadership of Dr. Leo H. Ley, Assistant Medical Director of Civil Defense and the chiefs of the Stations. It is planned that a Red Cross first aid course, which is the first requirement for volunteers, will be conducted this fall in Frostburg, to be followed shortly after by one in Cumberland, to supply the trained personnel to Stations 3, 4 and 5.

Dr. Leslie E. Daugherty is Medical Director of Civil Defense in Allegany County and emphasizes that the casualty clearing stations may prove of value should there be a large industrial disaster similar to the recent explosion at the Pittsburg Plate Glass plant. Preparations for disasters of this nature can provide time impetus necessary for the organization to acquire training and to stand ready to render the vital emergency service.



Dr. F. A. G. Murray, now 81 and in semi-retirement, lays away his surgical instruments.

This Is Your Life

Dr. F. A. G. Murray, has presented his instruments to the Allegany County Historical Society, where they will be placed in perpetuity in the medical room. Holding the obstetric forceps he has used for 58 years, (since 1899), he reminisced about his medical life to your reporter.

He has delivered 5400 babies in that span of years, practicing in the hinterland most of the time. Born in Baltimore in 1876, he early went to Finzel, Maryland, in Allegany County; beginning practice in 1899, at the insistence and recommendation of Dr. John E. Legge, now of Baltimore. Practice being somewhat slow the first year, with his own hands and the aid of a local laborer, he built his own home in the town of Finzel, in the summer of 1900. In 1901, his first child was born, having married a Baltimore lady who accompanied him to the wilds of Allegany County. Early in 1903, his practice having become extensive, he was forced to move to Mt. Savage for a more central location. He lived there until 1917, at the outbreak of World War I. He then joined the United States Army and afterwards returned to Allegany County, moving to Cumberland in 1919.

Dr. Murray's parents were of English origin. His father, who arrived in the United States in 1872, was an Episcopal minister. Dr. Murray was born in Baltimore in 1876 and was educated in Virginia, at Woodbury Forrest High School. The original family name was Moray and the present Queen Mother of England is a niece of his grandmother. The Murray family coat of arms, which hangs in his living room, is the combined coat of arms of the Murray and Smith families; his mother being a Smith. There were no titles on his mother's side of the family. The coat of arms shows the "hunter calling his hounds after the fox chase."

Dr. Murray was the first person in Mt. Savage to have an automobile, purchasing one from the late Governor of Maryland, the Honorable Lloyd Lowndes.

He believes he has performed over thirty thousand operations, being a pioneer in thyroid surgery. Over ninety per cent of all his deliveries were under chloroform and while he never did an episiotomy, he always immediately repaired the perineum, when torn.

While seemingly trying to gloss over his illustrious ancestry, I noted the many oil paintings on the walls of his lovely home. He considers himself a poor business man, but I succeeded in learning that he had grossed $20,000 from a $1500 business venture. One can truthfully say that what he didn't make in worldly goods, he made in friends. One professional commentator said "he probably was the best thyroid surgeon in Western Maryland in his day."

He is an Odd Fellow, Episcopalian and to this day, a friend of the poor and unfortunate.

Dr. Murray presented his entire collection of obstetrical forceps to the Society; one forceps was over one hundred years old.

Tri-Towns Area Needs Physicians

Extra physicians are needed in the following towns: Westernport, Mt. Savage and Flintstone. The Flintstone area covers one-third of Allegany County and since the death of Dr. J. A. Watson, these people have been without a physician, requiring them to call Hancock or Cumberland physicians. This necessitates a drive either way, of better than fifteen miles.

New Physicians in Cumberland

Dr. Ralph J. Zientek, has located in Cumberland in association with Dr. Benedict Skitarelic, in the practice of pathology. Dr. Zientek is a graduate of the University of Maryland and the Johns Hopkins University School of Medicine. He took postgraduate training in pathology at the University of Illinois and since that time has been assistant professor of pathology at the University of Illinois School of Medicine.

Dr. Ralph Roth, has returned to Cumberland and is associated in practice with Doctors Rathbone and Cawley, in the practice of radiology. He is planning to go abroad in the Fall, for further training on a Fellowship of the American Cancer Society.

Cruise to the Caribbean

Faculty members of the University of Maryland School of Medicine will go on a cruise to the Caribbean in November, aboard the liner Stockholm. Professors from the University of Maryland School of Medicine will hold a postgraduate course and Doctors Leo H. Ley, Jr., and James G. Stegmaier, from Cumberland, will attend the postgraduate course on board ship.

Doctors Speak at Graduation Exercises

The Sacred Heart Hospital, at a dinner-dance held at the Ali Ghan Shrine Country Club honoring the graduates of 1957 in the Sacred Heart Training School for Nurses, announced that it will close its doors within the next two years in Cumberland. Dr. Leo H. Ley served as master of ceremonies. The guest speaker was Dr. Blane M. Schlindler.

Training Course for Nurses in Civil Defense

A training course, consisting of 15 hours, under the direction of the Maryland Civil Defense Agency, was held in Cumberland in October. This course aimed to prepare the nurse for her Civil Defense job. Among topics for class work were: 1) Worldwide political situation; 2) Why we need A Civil Defense Organization; 3) Blast effects of Atomic and Hydrogen Bombs.

These lectures will tie in with the preparation of Civil Defense in natural disasters. Local physicians will participate in lectures on the mass treatment of casualties. Allegany County is preparing to care for a mass migration from the Baltimore and Washington areas, should an attack occur.

BALTIMORE CITY MEDICAL SOCIETY

Conrad Acton, M.D.

Journal Representative

The regular monthly meeting of the Executive Board of the Baltimore City Medical Society convened Tuesday, May 21, 1957. Mr. G. C. A. Anderson, our legal counsel, was present. There has been a change made in the Group Insurance liability policy. The Company has stated in its master policy that it *cannot* settle a case unless the attorney of the defendent allows them to do so. Heretofore the Company could settle a claim on the basis of cost

rather than principle. It was agreed that this strengthened rather than weakened the policy, and the Board approved the change. On the advice of Counsel, it was decided that the Insurance Company will be notified of new members elected to the Society. The carrier may solicit them directly. Members of the Society are urged to tell the individual new members about the availability and advantages of this policy.

A letter from the Washington National Insurance Company, the company holding the Group Life Insurance Plan for the Baltimore City Medical Society, revealed it has received $82,675 in premiums and has paid out $105,000 in claims since November 1, 1954, when this plan was made effective. This is not a very attractive piece of business. They ascribe the situation to the fact that the older members and uninsurables have got into the group and that the younger, more insurable members have not been participating sufficiently to make up the difference. The Company is anxious that something be done to improve the situation.

The Company suggests changing to a different type known as a "level-premium reducing-amount" Group Life Plan. The premium remains the same from year to year, and individuals would not be faced with the unpleasant experience of being asked to pay ever-increasing premiums. All members pay the same premium, but the amount of coverage decreases each 5-year period. This type of insurance is said to be especially attractive to younger men who need larger amounts of term insurance, and yet it is still attractive to older members. Under the new group plan the annual premium would be $120 to all members, and would remain constant. Up to age 40 the amount of insurance would be $20,000, decreasing proportionately at stated periods, until at age 70 the amount would be $1,000. The Board voted to wait until Dr. Kimberly, its authority on insurance, could give a more detailed evaluation of the proposal.

The Executive Board's contact with insurance carriers is not always a happy one, so it was a pleasure to get a letter from one of our members stating how well the Continental Casualty Company had responded to his claim for compensation during a recent hospitalization. The covered member was most pleased and gratified at the treatment his claim received, and wanted the Society to know that at least this carrier was doing a good job.

Dr. Sidney Scherlis presented the basic plan of a Public Education program, sponsored this year by the Maryland Heart Association. He felt that education of the physicians and the community with regard to its service and research was most important, particularly the lay Public Education Program. It was proposed to have seminars for patients referred to the program by their local doctor. The two aspects, the public and the patient, would be correlated by the National Heart Association. Some members of the Executive Board wondered if the public were not already supersaturated with such specialty programs. Apparently the Association, State and National, was all set and Dr. Scherlis's appearance was to make a formal plea for the approval of the Baltimore City Medical Society and for our endorsement of their aims and methods. Apparently the idea would be to dispense, through the medium of the doctors, information to the patients and—new this season—to have doctors refer to clinics by card those patients who would need education in cardiac conditions. In response to a question as to why the physicians can't do this for their patients, Dr. Scherlis stated that doctors in clinics and in their offices did not have the time to spend educating each patient. Several expressed the opinion that the pediatricians and the Heart Associations were doing an excellent job educating children and parents about the rheumatic type of heart disease. The advisability of the Heart Association entering the field of sclerotic heart disease was questioned because it was felt that public education should be given to people who want it, and not forced down their throats. The motion to approve it was *not* carried.

The Jenkins-Keough Bill, now in Congress, was brought to the attention of the Executive Board by Dr. Goldsborough, Chairman of the Legislative Committee, who recommended our support. Dr. Goldsborough, after a thorough study, asked that all physicians contact members of the Ways and Means Committee of the House of Representatives and our Senators to advocate support of the Bill (H.R. 9–10). For those who may not be as informed about it as others, the Bill permits setting aside amounts up to $5,000 per year as an endowment

for self-employed individuals. This $5,000 per year would be tax-free until used. The Treasury Department and Big Labor apparently oppose this. Self-employed individuals and insurance companies are definitely interested. It was voted that the Society be circularized, the Secretary to explain the reasons why the Society endorses it, and list the appropriate members of Congress to be contacted.

Dr. Wetherbee Fort, Chairman of the Zoning Committee of our Society, working with a Committee from the Dental Society and with Mr. Barnes, Director of Traffic in the City organization, has worked out a favorable zoning ordinance. It asks that the doctors be allowed to practice as such in residential areas where there is a need for doctors, and where local residents do not object. Mr. Anderson stated that this ordinance required the cooperation of the Zoning Board and the Planning Committee and certain City Agencies. He said that with the help of Mr. Barnes they have been able to work out the present ordinance, which they thought was very favorable to physicians and dentists. It has been published for 15 days according to the statutory requirements, and after that time a hearing will be set. The ordinance actually was introduced in City Council on May 20th. It was voted to authorize a circularization to the whole Society concerning the meeting to be held June 17th at 3:00 P.M. in the City Council chambers, third floor of City Hall, concerning Ordinance #1461. It was hoped that everyone would bring what pressure he could to secure the passage of this ordinance. As everyone in the Society knows, physicians practicing in certain residential areas have been subject to intermittent pressures to take space in projected professional buildings under implied threat of suit for practicing in a building in which they did not actually have their residence. While such practice arrangements have been a custom for many years, it is contrary to zoning regulations, and newcomers cannot take advantage of the "prior use" clause in the zoning ordinance.

Amendments to the Constitution and By-Laws dealing with the selection of the Nominating Committee have been hanging fire. Interested members of the Society are distressed that no action has been taken. It was the feeling of the Board that something should be done, and that Dr. Paulson, Chairman of the Constitution and By-Laws Committee, should be asked to get together with the interested parties and try to effect appropriate changes. A Special Meeting was proposed, but since amendments to the Constitution can be presented only at Regular Meetings, this would serve no real purpose. A meeting of those interested with the Constitution and By-Laws Committee could act as a steering group and keep things rolling.

Repercussions from the meeting called to consider the recommendations of the Planning Committee, and the actions of the House of Delegates, were presented by Dr. Classen, Secretary. Actually only 44 members out of the some 1400 members of the Society were there. There was considerable bitter feeling among those present, according to Dr. Classen, that the Society had not been informed properly of such serious proposed changes. Dr. Classen requested that the action the Delegates took on this Planning Committee report should be distributed, to keep the absent membership up to date, particularly since it takes so long for these things to appear in the *Journal*. Dr. Classen was authorized to send out such a report.

A most important communication was received from the Dorchester County Medical Society concerning the Workman's Compensation Law. Dorchester County is taking up the cudgels against the interpretation of the Maryland Workman's Compensation Law. The employer's responsibility for supplying the employee with medical attention has been interpreted to mean that the employee *must use* the physician *selected by the employer*, and in effect this does not give the employee a free choice of a doctor. This, the letter states, is basically wrong. Our Executive Board agrees with the Dorchester County Medical Society and concurs with the idea that everyone should have a free choice of doctors. The Board authorized notifying the Dorchester County Society that it was in favor of effecting a change of interpretation. Furthermore, it was felt that this was too important a matter for the Executive Board as a whole and that this should be brought up for a vote at the first Regular Meeting in the fall. The result of this voting is to be communicated to the Dorchester County Society.

Your *Journal* Correspondent gives his own three silent cheers for the Dorchester County Society in

leading this crusade. Most of us have experienced the sorry situation that occurs when a patient is forced to go to an "Insurance Doctor," usually under the implied threat of having to pay all expenses personally and hazard loss of employment. No patient, and no physician, wants to make himself conspicuous target for retaliation. Nor does one want to crusade and spend hours filling out forms and possibly arguing before the Compensation Commission regarding the propriety of his own treatment of a patient. There must be some happier solution than the present carrier dominated arrangement. I hope that this crusade will be joined by all the other Component Societies and lead to a resolution of the impasse.

Listing in the telephone book of Hospitals and Nursing Homes in one combined list was brought to the attention of the Society by Dr. Samuel Morrison. Dr. Morrison feels that it is wrong for rest homes, convalescent homes and nursing homes to be listed in the telephone book as "Hospitals." The Executive Board agrees with Dr. Morrison, and voted to contact the telephone company and the Hospital Council, Inc., to find out why this was done, and whether it would be feasible to change it.

Three Grievance Committee cases were considered by the Board. In each instance it was felt to be a matter of misinterpretation and misunderstanding, and the Secretary was instructed to communicate this opinion to both parties involved in each instance, to see if arbitration could be effected.

* * *

Through the convivial arrangements of members, the Executive Board had a dinner meeting on Tuesday, July 16 at the Elkridge Club. The agenda was completed in a cool upper room, defying the sweltering heat of the rest of the town.

The first order of business was a petition for a Section on Medical Hypnosis. Ten doctors, members of the Baltimore City Medical Society, signed the petition, and it was discussed freely. The request was in proper form, according to the Constitution. The Board fell back on the basic stand that too many sections disrupt and divert the Society. A certain number of Sections seem to be efficient and necessary. Sections in splinter specialties are considered unwise and frowned upon. It was the feeling of most of the members present, none of them psychiatrists, that hypnosis probably should come under the neuro-psychiatric section. This decision was to be conveyed to the group of doctors sponsoring the petition, with the request that some coordination with the neuro-psychiatric section, a well established branch, should be effected.

The Annual Report of the Woman's Auxiliary was read, and the Board unanimously voted to thank Mrs. E. Ellsworth Cook, President, for the fine work that they have done, and express appreciation for their continued support and help.

The incoming President of the Auxiliary, Mrs. Whitmer B. Firor, wrote to inquire whether the serving of refreshments following the Regular Meetings of the Society continued to be desired. This point was discussed, and it was voted that we should request a continuation of this service through the coming year.

The President, Dr. Geraghty, reported on a luncheon meeting with Mr. Winslow Parker and other representatives of civic and industrial organizations concerning the present state of federal taxes and the possibilities of reduction. The meeting centered around a discussion of the Sadlac Bill (H.R. 6452). A representative of the National Association of Manufacturers spoke at that meeting and recommended that this bill would be beneficial to manufacturers, doctors, and the population at large. Dr. Goldsborough, Chairman of our Legislative Committee, is studying the Bill at the present time, but his report has not yet been submitted. The Executive Board felt that provided the Legislative Committee agreed, Dr. Geraghty should circularize the membership with regard to favoring the Sadlac Bill.

A list of delinquent members was discussed. Members who for one reason or another have paid none, or only part, of their dues. Resistance to the assessments and other special features of our composite dues was discussed. It was voted that members in arrears after being warned of the deadline should be dropped from the Society. Since loss of membership automatically means loss of privileges in some hospitals, due notice is to be given. Once dropped, the whole process of reelection is required before membership can be regained.

BALTIMORE COUNTY MEDICAL ASSOCIATION

SAMUEL P. SCALIA, M.D.

Journal Representative

Mount Wilson State Hospital was the scene of the June meeting of the Baltimore County Medical Association. Dr. William Newcomer was our host.

The ladies of the Auxiliary presented their eighth nursing scholarship to Miss Patricia Stansbury of the Reisterstown High School. This is an annual project of the Woman's Auxiliary and the ladies are to be highly congratulated for their good work.

Our president, Dr. William Pillsbury, reported that the Association had received a Certificate of Merit from the Baltimore County Council of Parent-Teacher Associations in sincere and grateful appreciation for outstanding services to children and youth. He also gave a report of the Committee to Study School Health Programs with recommendations to the School Health Coordinating Council. With the cooperation of our medical society, the school health program has gone a long way during the past school year and will continue to do so.

Dr. Pillsbury reported that he had attended two recent meetings of the County Council, as an observer for the county medical society. Because of certain criticisms of the County Health Department, as of July 1, the Johns Hopkins School of Public Health and Hygiene will make a study of administration and procedures performed by the Health Department. Speaking for the medical society, Dr. Pillsbury expressed our confidence and faith in Dr William H. F. Warthen and his department.

The scientific session was devoted to a wonderful talk by Dr. John Miller, thoracic surgeon at Mount Wilson. His topic was "Surgery in Pulmonary Tuberculosis."

FREDERICK COUNTY MEDICAL SOCIETY

LOUIS R. SCHOOLMAN, M.D.

Journal Representative

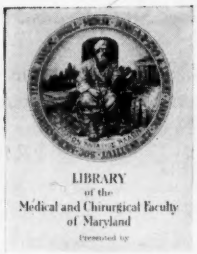
SOCIETY NEWS

The Frederick County Medical Society held its only summer meeting at Camp Kanawha, a fishing camp on the Potomac near Lander. It was an evening of relaxation enhanced by conviviality and excellent steaks. The speaker of the evening was Dr. Thomas Lee, a resident in surgery in Washington, who very entertainingly presented his talk on medical illustrations.

We have an influx of new practitioners. In addition to the return of a semi-native, Dr. Ernest Dettbarn, who has resumed general practice after a two year tour in the Navy, we have three newcomers: Dr. Robert Crouch, a specialist in G-U; Dr. Jules Langlet, who has opened offices for General Surgery in Brunswick and Frederick; and Dr. George Brinkley, Jr., an Obstetrics and Gynecology man. Dr. Dettbarn did not return to Frederick City, but instead joined Dr. James Stoner in a rural practice in the Walkersville-Woodsboro sector. Dr. Brinkley at this time has not as yet opened his office.

HOSPITAL NEWS

The July meeting of the medical staff of the Frederick Memorial Hospital was held on the first day of the month. Dr. Schoolman spoke on acute barbiturate intoxication. At the August meeting Dr. Ralph Michels spoke on the medical indications for scalene lymph node biopsy and Dr. F. S. Damazo described the surgical technique.



Library

Louise D. C. King *Librarian*

"Books shall be thy companions; bookcases and shelves,
thy pleasure-nooks and gardens." *Ibn Tibbon*

NEW BOOKS

Surely among the recent acquisitions listed below, you will wish to read at least one or two. We will be glad to mail them to you *free of charge*. Drop us a card specifying those you wish to see.

Abramson, Harold A., The patient speaks. N. Y. 1956.

Allen, Edgar V. & others, Peripheral vascular diseases. 2d. ed. Phil. 1956.

Allen, J. Garrott & others, eds., Surgery. Principles and practice. Phil. 1957.

American College of Chest Physicians, Clinical cardiopulmonary physiology. N. Y. 1957.

Artz, Curtis P. & Reiss, E., The treatment of burns. Phil. 1957.

Asboe-Hansen, G., ed., Connective tissue in health and disease. Copenhagen, 1954.

Bakay, Louis, The blood-brain barrier. . . . Springfield, 1956.

Bettmann, Otto L., A pictorial history of MEDICINE. Springfield, 1956.

Brugsch, Heinrich G., Rheumatic diseases, rheumatism and arthritis. Phil. 1957.

Burks, James W., Jr., Wire brush surgery. Springfield, 1956.

Charny, Charles W. & Wolgin, W., Cryptorchism. N. Y. 1957.

Chatfield, Paul O., Fundamentals of clinical neurophysiology. Springfield, 1957.

Commission on Chronic Illness, Long-term patient. v. 2 Cambridge, 1956.

Davis, Harry A., Surgical physiology. N. Y. 1957.

DeSanctis, A. G. & Varga, C., Handbook of pediatric medical emergencies. St. Louis, 1956.

Dorcus, Roy M., ed. Hypnosis and its therapeutic applications. N. Y. 1956.

Foldes, Francis F., Muscle relaxants in anesthesiology Springfield, 1957.

Gelvin, E. Philip & McGavack, T. H., Obesity. . . . N. Y. 1957.

Gillies, Sir Harold & Millard, D. Ralph, Jr., The principles and art of plastic surgery. 2v. Boston, 1957.

Gleason, Marion N. & others, Clinical toxicology of commercial products. . . . Balt. 1957.

Graham, John R., Treatment of migraine. Boston, 1956.

Guttmacher, Alan F., Pregnancy and birth. . . . N. Y. 1957.

Grollman, Arthur, ed., Clinical physiology. . . . N. Y. 1957.

Heidelberger, Michael, Lectures in immunochemistry. N. Y. 1956.

Hoagland, Hudson, ed., Hormones, brain function, and behavior. N. Y. 1957.

Hubbard, John P., ed., The early detection and prevention of disease. N. Y. 1957.

Kappers, J. Ariëns, ed., Progress in neurobiology. N. Y. 1956.

Kerr, Donald & Brunnstrom, Signe, Training of the lower extremity amputee. Springfield, 1956.

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Köhler, Alban & others, Borderlands of the normal and early pathologic in skeletal roentgenology. N. Y. 1956.

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Health Departments

BALTIMORE CITY HEALTH DEPARTMENT

Asian Influenza

Representatives of the Maryland State Department of Health and the Baltimore City Health Department met on August 8 with the State Advisory Committee on Influenza and after serious deliberation issued the following statement:

1. The Asian strain of influenza is new to this country and the population has little or no immunity to this virus. A number of limited outbreaks have already occurred in the United States. It seems likely that the disease will become widespread during the coming winter.

2. The disease has thus far been mild, although there is a possibility that it may become more severe.

3. A vaccine against Asian influenza is being produced in quantity but as yet only limited tests have been made with respect to its effectiveness and frequency of reactions.

In view of the foregoing situation, the Committee is reluctant at this time to recommend widespread vaccination of the general population. Health officials and the Advisory Committee, however, will be in close touch with the studies and developments now in progress and will report to the public at intervals.

It is, however, recommended that steps be taken now to prepare for vaccination of essential personnel, such as those in hospitals, and of groups of chronically ill or aged patients living under crowded conditions which favor infection.

It is to be emphasized that influenza is a greater hazard in the colder months. There is yet time to obtain information on these essential points and amplify the program, if indicated.

The State Advisory Committee on Influenza was appointed by Dr. Perry F. Prather, Director of the State Department of Health on June 20. The members of the committee are: Dr. Theodore E. Woodward, Chairman, *Professor of Medicine, University of Maryland School of Medicine;* Dr. Alexander S. Dowling, *Medical Director, Montebello Chronic Disease Hospital;* Dr. George S. Mirick, *Physician-in-Chief, Baltimore City Hospitals;* Dr. Winston H. Price, *Associate Professor of Epidemiology, The Johns Hopkins University School of Hygiene and Public Health;* Dr. Philip E. Sartwell, *Professor of Epidemiology, The Johns Hopkins University School of Hygiene and Public Health;* Dr. Thomas B. Turner, *Dean of the Johns Hopkins School of Medicine;* the Commissioner of health of Baltimore and Dr. Charles L. Wisseman, Jr., *Professor of Microbiology, University of Maryland School of Medicine.*

Huntington Williams, M.D.

Commissioner of Health

STATE DEPARTMENT OF HEALTH

Influenza—Comments on the Disease and a Guide for Laboratory Confirmation

Early in April of this year, influenza of epidemic proportions appeared in Hong Kong and Singapore. Then in rapid succession, almost simultaneous epidemics occurred in Taiwan, the Philippines, the Malayan States, Indonesia, Japan and India. The presence of the U. S. Army's 406th Medical General Laboratory in Japan provided unique circumstances for the study of this disease. Viruses were isolated from throat washings during the earliest epidemics and studied at various specialized influenza laboratories, including the Walter Reed Army Institute of Research, the World Health Organization Influenza Laboratories and the laboratories of members of the Commission on Influenza of the Armed Forces Epidemiological Board. Results of careful analyses revealed the presence of a new family of Type A influenza virus which is strikingly different from any previously isolated viruses. This new strain of virus is now called Asian influenza A. Numerous reports in the daily press have followed the spread of Asian influenza throughout the world. It is timely

therefore to review some of the epidemiological aspects of the disease.

Influenza has been known for many hundreds of years in all parts of the world. It seems to occur somewhere almost every year, sometimes affecting either a few individuals or specific groups within a small area. Sometimes it is regional within a country; breaks out in several countries; or erupts in large areas of the world. The various names by which influenza is known give a clue to its international character. At the end of the last century it was called Chinese influenza when it occurred in Russia, Russian influenza when it broke out in Western Europe, European influenza by the Americans and American influenza in Japan; earlier in this century it was labelled the Spanish influenza.

Much scientific work has been done since the influenza virus was discovered 24 years ago by Smith, Andrewes and Laidlaw, and the picture is not nearly so simple as it seemed then. We now know there are at least four different types of influenza viruses called A, B, C, D, and that within each type there are many different strains. In fact, one of the peculiar traits of the influenza viruses is their capacity to appear as different strains from year to year. For example, the epidemic which had its onset in Hong Kong this April and has spread to many parts of the world since then, is due to a previously unidentified and very different strain of type A influenza virus, now designated as Far Eastern or Asian Influenza A.

There are now well developed systems for quickly communicating information about influenza.

The International Influenza Center for the Americas, which is concerned with influenza in the Western Hemisphere, was recently transferred to the Communicable Disease Division of the U. S. Public Health Service in Montgomery, Alabama. There are public health officials in every state in the Union designated as Influenza Observers who are on the alert for local evidence of unusual occurrences of respiratory diseases.

In Maryland, as in other state and local health departments, health officials keep in close touch with various divisions of the U. S. Public Health Service. The Maryland State Department of Health has recently appointed an Advisory Committee on Influenza, composed of expert scientists and physicians from both medical schools and the Baltimore City Health Department. This Committee advises the State Health Department on control measures and policies as the situation develops. The State Health Department has provided current information about influenza to all of its 23 health officers, who in turn keep physicians in their counties informed.

A laboratory diagnosis of Influenza is especially important at the early stages of an epidemic, when the first unusual clustering of cases of respiratory diseases is noted. The following guide may be useful to the physician who is faced with such a situation.

There are 2 types of specimens required for the diagnosis of influenza: *throat washings*, from which viruses can be isolated for type and strain identification and *blood samples* (paired), which will show antibody response.

A. Throat Washings

1. Insulated cardboard mailing cartons which will accommodate 10 pounds of dry ice, a specimen identification and history slip, and a screw-top specimen jar containing 50 ml. of sterile broth can be obtained at local Health Departments. Additional specimen jars will be available so that as many as 5, but no more, specimen bottles can be shipped in a single mailing carton if necessary.

2. Throat washing specimens should be obtained during the first 3 days of illness and while the patient is still febrile (although virus may be recovered as long as 7 days after onset).

3. The patient should gargle 3 times with the broth supplied in the specimen jars, using about 15 ml. each time and returning the washing each time to a paper cup. The entire contents of the paper cup is then to be transferred to the specimen bottle for transportation to the laboratory.

4. If a delay of a few hours is necessary before a specimen can be sent frozen to the laboratory, it should be kept chilled at refrigerator temperature. When longer periods of storage are unavoidable, the washings must be kept in a deep freeze at minus 18° C.

5. All specimens are to be shipped in 10 pounds of dry ice directly to the regional influenza laboratory which is serving Maryland: Dr. T. P. Magill, State University of New York, College of Medicine, 335 Henry Street, Brooklyn 1, New York.

6. Each County Health Officer can determine the

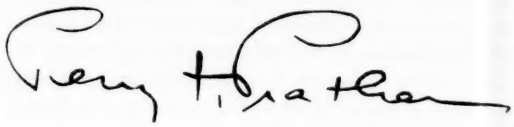
best local source for the purchase of dry ice and the method of shipping specimens which would be speediest, whether via parcel post, special delivery or express or other means.

B. Blood Samples

1. Two specimens of whole blood should be taken, one as early as possible during the acute illness and the second sample 2–4 weeks later.

2. Each specimen should contain 5–8 ml. whole blood, collected in a miscellaneous blood kit, allowed to clot and then mailed to the Central Laboratory, Maryland State Department of Health, 16 E. 23rd Street, Baltimore 18, Maryland.

3. *Two* blood specimens are *absolutely* necessary to determine serologic response—a single test cannot be interpreted.



Director

STATE OF MARYLAND DEPARTMENT OF HEALTH

MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, September 1–26, 1957

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT. AND SERUM	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON-PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS: Influenza and pneumonia
Total, 4 weeks																		
Local areas																		
Baltimore County	1	—	—	—	1	—	3	—	—	—	5	—	1	6	—	3	—	3
Anne Arundel	—	—	1	—	—	—	—	—	—	1	1	—	—	2	—	2	—	2
Howard	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—
Harford	—	—	—	—	—	—	—	—	—	—	—	—	—	12	—	—	—	—
Carroll	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—
Frederick	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Washington	—	—	—	—	—	—	—	—	—	—	—	1	—	4	1	1	—	1
Allegany	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	—	—	—
Garrett	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Montgomery	—	—	—	—	—	—	2	1	—	1	4	—	2	12	—	—	m-1	4
Prince George's	—	—	—	—	—	—	—	2	1	—	—	—	—	5	—	1	—	2
Calvert	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	—	—
Charles	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—
Saint Mary's	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Cecil	—	—	—	—	—	—	—	—	—	—	—	—	1	2	—	—	—	—
Kent	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—
Queen Anne's	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—
Caroline	—	—	—	1	1	—	—	—	—	—	—	—	—	—	—	—	—	—
Talbot	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	1
Dorchester	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—	—	2
Wicomico	—	—	2	—	—	—	1	—	—	—	—	—	—	1	—	1	—	—
Worcester	—	—	—	—	—	—	1	—	—	—	—	—	—	1	—	—	—	—
Somerset	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Total Counties	1	0	3	1	2	0	7	4	1	2	10	1	5	54	2	14		15
Baltimore City	9	0	1	1	37	0	19	0	0	0	9	1	28	85	13	512		12
State																		
Sept. 1–26, 1957	10	0	4	2	39	0	26	4	1	2	19	2	33	139	15	526		27
Same period 1956	27	0	16	4	25	0	61	24	6	0	8	0	12	125	16	579		29
5-year median	17	1	8	13	13	2	35	78		4	21	4	24	148	19	628		28
Cumulative totals																		
State																		
Year 1957 to date	1905	2	247	87	1115	24	1968	12	2	20	796	7	311	1305	185	5184		459
Same period 1956	2455	1	1079	78	9242	42	2607	54	11	14	669	15	118	1543	200	5277		512
5-year median	3043	11	529	250	5962	36	1833	167		26	1272	15	274	1579	165	5736		472

m = meningitis, other than meningococcal.

Book Reviews*

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them.

Another Public Health Measure Becomes a Focus of Public Attention. **The Fight for Fluoridation.** By Donald R. McNeil. 241 pp. Oxford University Press, New York, 1957.

Fluoridation has taken its place with the licensing of medical practitioners, sanitation proposals, pasteurization, immunization and chlorination as a subject of one of the most bitterly fought campaigns in American history. The author, by virtue of his position as associate director of the Wisconsin State Historical Society, was on the scene in 1945 when the campaign was begun.

Many years of epidemiological study had disclosed the relationship between mottled enamel, tooth decay and fluoride bearing domestic waters. A "Fluorine Study Committee" had been appointed by the Wisconsin State Dental Society. The committee had spent two years investigating the chemistry of fluorine, its toxicity, the effects of fluoride in drinking water, the legal aspects of fluoridation and the potential attitude of municipal officials. Every phase of the problem seemed favorable. On March 19, 1945, the society's house of delegates voted unanimously to recommend that all Wisconsin drinking water supplies deficient in fluoride be fluoridated to the 1.0 part per million level. By April, the state board of health was convinced. In July the dentists and physicians of Madison had approved. Madison's board of water commissioners were next in September and the city board of health in October. There seemed to be no opposition. Then two aldermen began a counter-campaign. The battle was joined—and it has been raging ever since!

Mr. McNeil's account of the struggle for fluoridation—the determination and enthusiasm of its promoters, the vociferousness and vigor of its dissenters and the bewilderment of the citizenry—is accurate, informative and highly readable. It is basically a study of people and their motivation in the difficult but uniformly successful process of adopting a scientific public health measure in a democratic environment. It is well worth the few hours needed to read it.

H. B. McC.

* The reviews here published have been prepared by competent authorities and do not represent the opinions of any official bodies unless specifically stated.

Ancillary News

NURSING SECTION

M. RUTH MOUBRAY, R.N., *Executive Secretary,*
Maryland State Nurses Association

STUDY REVEALS NATION'S NEED FOR PROFESSIONAL NURSES

The need to attract more young people to a career in professional nursing and to expand nursing school facilities to train enlarging student bodies is cited in a study issued today by the National League for Nursing. The study, published under the title "Nurses for a Growing Nation," will be released to the organization's membership at its biennial convention in Chicago, May 6–10.

From a present 430,000 professional nurses—or a ratio of 258 to every 100,000 people—the nation will need 600,000 nurses by 1970 to increase the ratio to 300 for this population segment, and 700,000 nurses to raise the ratio to 350. The study assumes that the ratio should be bettered nationally in view of the many nursing positions that remain vacant, the hospital services curtailed for lack of professional nurses and the needs to expand nursing service in public health, industry and other fields.

If nursing continues to attract its present proportion—4%—of the growing number of college-age girls, the profession can expect to reach the 300 ratio by 1970, the study points out. However, a national goal of 350, already reached or exceeded by six states, can be attained only if some of the currently-operating trends in nursing are reversed. Among the factors that may make it possible to reach the higher goal are: 1) attracting more students to nursing than present trends anticipate, and 2) reducing the high withdrawal rate in schools of professional nursing to assure more graduates.

Nursing schools face unprecedented expansion if the ratio of nurses to population is to be maintained, and especially so if more students are to be prepared to meet the heavy demands for nursing service. The study reveals that if the current annual rate of approximately 45,000 admissions to schools of nursing continues, the ratio of nurses to population will drop from its present 258 to 246, when instead there is an obvious need to increase it.

The extent to which the two major types of basic education programs in nursing—diploma-associate degree programs in hospital and junior colleges and baccalaureate degree programs in colleges and universities—is indicated in the study by applying educational patterns in nursing to the job responsibilities of professional nurses. Nurses who work under supervision, such as bedside nurses in hospitals and doctor's office nurses prepare in diploma and associate degree programs, the study reveals. These nurses compose 67% of the professional nurses in active nursing jobs. The remaining 33% who become head nurses, public health staff nurses, teachers, administrators and supervisors should prepare initially in baccalaureate degree programs and the portion of these nurses who go on to top leadership positions should undertake graduate study.

Although the consensus of many nursing educators bears out this conclusion of the NLN researchers, "Nurses for a Growing Nation" marks the first published statement on the job responsibilities for which the various basic nursing programs appropriately prepare students. The study points out, however, that education alone does not make a good nurse.

Regional, state and local leagues for nursing and other planning groups are charged by the NLN with responsibility for applying the study to their own areas and communities and of stimulating public discussion of the findings. Public support of programs to expand nursing education facilities and to obtain the many nursing teachers who will be needed to train the students, is urged strongly in the study. It also raises as a significant question: How can the cost of expansion in nursing education be met?

"Nurses for a Growing Nation" is a 36-page booklet, printed in two colors, using graphs and charts. It sells for 35¢ a copy from the National League for Nursing, Two Park Avenue, New York 16, N. Y.

Blue Cross - Blue Shield

THE ROLE OF THE DOCTOR IN BLUE SHIELD

By DENWOOD N. KELLY*

Last month on this page we discussed the more formal relationships between Maryland Blue Shield and its participating physicians, particularly the liaison maintained through the Medical Relations and Reference and Appeals Committees. We also mentioned some of the Plan's activities in the field of physicians' relations. This month we'd like to talk about the doctor's role in Blue Shield.

Just recently two prominent physicians have commented on this particular point, offering sound counsel on shaping the course of Blue Shield. Dr. Fred Sternagel, President of the Iowa State Medical Society, and Dr. James W. Colbert, Jr., St. Louis University's Dean of Medicine, both agree that the future of Blue Shield Plans depends upon the guidance the profession gives to their development.

On the President's Page in the Iowa Journal for June, Dr. Sternagel reminded his colleagues that Blue Shield must continue to shape its course in accordance with changing conditions and public demand so that the program would continue to serve as an effective means of budgeting the cost of medical care.

"Blue Shield's job," wrote Dr. Sternagel, "is not yet finished for the spectre of 'socialized medicine' still haunts us. We shall have to cooperate intelligently and unselfishly, if our Plan is to protect the dignity of individual enterprise. It is clear that this program cannot continue to maintain leadership in a competitive field unless we work more closely (with it) than ever before."

Meanwhile, in San Francisco, Dr. Colbert told an annual staff day audience at St. Mary's Hospital that "it is absolutely essential that the Plans do not get out of the control of the medical profession; if they do, the profession and the welfare of the patient will both suffer."

The thoughts expressed by Drs. Sternagel and Colbert are to the point. They place in sharp perspective the fundamental principle on which Blue Shield Plans were organized and must continue to operate. And today, perhaps more than ever before, developments in the health prepayment field necessitate a dedication to the principle of physician control with renewed vigor.

What Dr. Sternagel and Dr. Colbert were saying is clearly and concisely the clue to Blue Shield progress. Their ideas are basic . . . for it is in fact the physician's leadership, guidance, and active participation that are fundamental to the principles and objectives Blue Shield Plans were organized to serve. It is obvious, therefore, that the degree to which the profession contributes to the development of Blue Shield is alone the factor determining the extent to which Blue Shield will *serve the profession and the public best.*

With its strong ties to the profession through medical society sponsorship, your Blue Shield Plan *can* fully serve both professional interests and the public's need for a satisfactory means to budget medical care costs. And over the years, active physician participation in the affairs of Blue Shield has been encouraged and earnestly sought because those of us who administer the Plan recognize that in matters of providing health care coverage, it is the physician's judgment, leadership, and counsel that must prevail. It is only under these conditions that health care coverage consistent with the values and traditions of American medicine can continue to flourish and serve the public fully.

* Assistant Director, Maryland Medical Service, Inc.

Woman's Auxiliary Medical and Chirurgical Faculty

MRS. HOMER ULRIC TODD, SR., *Auxiliary Editor*

REPORT OF NATIONAL CONVENTION

New York, N. Y.—June 3–7, 1957

MRS. E. RODERICK SHIPLEY, *President-Elect*

The formal opening of the 34th Annual Convention of the Woman's Auxiliary to the American Medical Association was held in the Grand Ballroom of the Roosevelt Hotel, New York City, June 3, 1957.

Mrs. Robert Flanders, the president presided.

Miss Whitelaw, of the National Foundation for Infantile Paralysis presented to Mrs. Flanders a citation for the work that had been done by the Medical Auxiliary, in helping with the tremendous task of inoculations.

Mrs. Flanders, in her presidential report, made the following observations:

1. Her attendance at the Traffic Safety meeting held in Washington by President Eisenhower. This traffic safety is one of the prime considerations for the Auxiliary for the coming year.

2. Mrs. D. D. Caples of Maryland was appointed to the National Council on Careers.

3. Assistance of the Auxiliary is being requested more and more by the A. M. A.

4. Mental health, recruitment and legislation should be given first place on the agenda for the coming years.

Mrs. Paul C. Craig, the President Elect, was introduced and made an interesting address which included the founding of a student A.M.A. Auxiliary in Philadelphia.

The Treasurer, Mrs. Gold, reported assets of $185,000.

The transactions of the Pre-convention meeting were reported as follows: A contribution in memory of Mrs. Boone to A.M.E.F. Ten per cent of the budget is to go to A.M.E.F. One hundred dollars is to go to each of the following: Rural Health Association, Student A.M.A. Auxiliary, Crusade for Freedom, and the Committee for Careers in Nursing.

Mrs. Frances Fargher reported on the A.M.E.F. New phamphlets are being put out entitled, "Keep These Doors Open." The amount of $113,816.37 was donated through the Auxiliary this past year. Of this amount $106,349.77 was sent in by the Counties and States.

Mrs. Goodhand reported on legislation. There will exist henceforth a closer relationship with the Committee on Legislation. This new set up will be arranged in this manner:

1. Legislation Chairman of the National Auxiliary is to be invited to all A.M.A. conferences.

2. Under that there will be area chairman, who will keep in touch with key legislative representatives from each state.

3. Under that the state chairman is to keep the counties informed.

4. The area chairman for Maryland is Mrs. H. Hanford Hopkins of Ruxton.

The Recruitment Chairman reported that the Future Nurses Club of Glen Burnie had won the Parent's Magazine Award. There are 2000 nurse clubs, 1118 are auxiliary sponsored. Two hundred seventy five (275) clubs were surveyed and 66% of the members were found to have gone into the field of nursing.

Mrs. Harold, reporting for revisions and by-laws, informed the members that the proposed revisions to the constitution and by-laws were not voted on because of the pending incorporation of the National Auxiliary.

"Today's Health" reported an increase of 19,000 subscriptions over last year. Awards were given for top subscription percentages.

The Credentials Committee reported 1273 attending the meeting. There were also three from Australia, two from Brazil and two from Canada attending the meetings.

The following resolutions were proposed and voted on:

1. A resolution was passed regarding the necessity of carrying a first aid kit in every car. The automobile is an ambulatory type of bomb. It was decided unanimously to adapt and design a kit as standard. Copies of this resolution are to go to the Chairman of National Defense of the A.M.A.

2. Traffic Death Resolutions: All other carriers are safeguarded by law as to speed and safety devices. President Eisenhower's Traffic Death meeting emphasized the gravity of this problem. Therefore be it resolved to support the A.M.A. act regarding automobile safety. A copy of this resolution is to go to the President of these United States.

3. A resolution was passed of appreciation to the retiring officers and the Convention Chairman, the Doctors and all others who contributed to the success of the convention.

The slate for new officers was presented and unanimously approved by voice vote.

Mrs. George Garris reported on the project, "Student A.M.A. Auxiliary." It will be a training program for the wives of future physicians. They are to be an auxiliary in their own right. They are to be sponsored by the Auxiliary, who will help them with speakers, teachers, and open their homes to them. This project will be at no cost to the Auxiliary, but the reward will be great and the results far reaching.

Mrs. Paul C. Craig took the chair as the newly elected president. She announced that the theme for the coming year will be, "Health is a Joint Endeavor." We must work with the A.M.A. under the state of mutual understanding. Evaluate how well we work together and what we will do. How effectively do we carry out our projects? We are a working community service organization. We must utilize all methods to keep up with changing times. This year we shall study group behavior. Our emotional understanding of what we are attempting contributes greatly to our success.

IMPORTANCE OF MEMBERSHIP!

On membership depends the whole. Membership is the skeleton of our structure. With this in mind, membership chairmen should plan their campaign now, *before* activity starts.

Some Auxiliaries have had a remarkable success this year, but effort must be maintained *every* year, for membership today gives no guarantee of participation tomorrow. We are fortunate that our organization is based on "man's need of woman's services," for where women can serve actively they will go, but it is up to the leaders to help them serve actively.

Membership participation, program and projects are inseparable. Remember that in your planning and don't try to be a lone wolf.

INAUGURAL SPEECH

MRS. DAVID S. CLAYMAN*

MRS. DAVID S. CLAYMAN

Once again the time has come for a new President of the Woman's Auxiliary to take office. You have conferred upon me the greatest honor which may

* President, Woman's Auxiliary of the Medical and Chirurgical Faculty of the State of Maryland.

come to any member of the Auxiliary and I find that words are so empty when it comes to expressing my deep gratitude for the confidence you have shown in me to elect me to the highest office it is within your power to bestow. My one great desire is that I may prove worthy of your trust.

It is with a very deep sense of humbleness and humility together with a great pride for the privilege you have bestowed upon me that I approach the task which lies before me. In the light of my association with you during the past years, it would be impossible for me to accept my task lightly, as I know the responsibility and the work which lies ahead. Yet, I look forward to accomplishing this task because I have perfect confidence in the loyalty of the membership and their willingness to cooperate.

It is our proud privilege and heritage to be an auxiliary to the greatest public service organization in our State, The Medical and Chirurgical Faculty of the State of Maryland. It is not my intention to delve into a long discourse on the many aspects and objectives of Auxiliary work. However, I feel that I should impress upon each of you the fact, that regardless of where your interests may lie, the Auxiliary has a program for everyone of you. We support legislation, national and state, relative to Health Problems and Medical Education; We support civil defense which includes home nursing, first-aid and blood bank. . . . all of which could someday be responsible for saving many lives; We support a recruitment program for nursing and allied professions. We support mental health and many other programs.

Our Constitution states our objectives to be (1) through our members to extend the aims of the medical profession to all organizations which look to the advancement of health and health education; (2) to fulfill such functions as may be desired and requested from time to time by the Medical and Chirurgical Faculty of the State of Maryland; (3) to cultivate friendly relations and to promote mutual understanding among physicians' families. Each of these objectives is important and vital to the medical profession in Maryland. No one member nor one county can do this alone. The degree of success in accomplishing these objectives depends primarily on the willingness of each individual member to do her part.

One of our aims for this coming year is the further expansion of membership and the organization of more County Auxiliaries. Some counties feel they have too few women to organize, but if they will join as members-at-large and associate with their neighboring auxiliaries, I feel confident they will become interested and will thereby form a nucleus for future auxiliaries.

There are many challenges for us . . . one of the greatest is in the field of public relations. Each doctor's wife needs to be informed and keep informed so that she may be prepared to talk with the lay people she meets daily, when questions pertaining to medicine are asked. How may we best prepare ourselves to serve our communities in the field of health? To help us in all these important tasks, we have the Bulletin of the Woman's Auxiliary to the American Medical Association. The only way we can avail ourselves of this help is to subscribe to the Bulletin. But until we all start reading and using the material presented to us, we are not beginning to do our job. I therefore strongly urge all of you to make full use of this help which is available to us. Let us work together for progress in all facets of our Auxiliary work.

I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals. I pledge my sincere efforts in meeting the challenge to carry on the traditions of our organization. I shall strive to merit your confidence and the honor of serving as your president and I sincerely hope that I may prove worthy of your trust. Thank you.

Coming Meetings

All meetings are held in the Medical and Chirurgical Faculty Building, 1211 Cathedral Street, Baltimore, Md. unless otherwise designated.

NOVEMBER 1957

BALTIMORE CITY MEDICAL SOCIETY

Friday, November 1, 1957, 8:30 p.m. — 1211 Cathedral Street

MARYLAND SOCIETY OF ANESTHESIOLOGISTS

Tuesday, November 5, 1957, 8:00 p.m. — 1211 Cathedral Street

SECTION ON DISEASES OF THE CHEST, B. C. M. S.

Speakers: Dr. Paul Molumphy
Dr. John DeCarlo

"Pulmonary Embolization from Septic Pelvic Thrombophlebitis"

Wednesday, November 6, 1957, 8:00 p.m. — Chronic Building, Baltimore City Hospital

PEDIATRIC SECTION, B. C. M. S.

Tuesday, November 12, 1957, 8:30 p.m. — 1211 Cathedral Street

OTOLARYNGOLOGICAL SECTION, B. C. M. S.

Tuesday, November 12, 1957, 6:00 p.m. — Johns Hopkins Club

COMMITTEE FOR THE STUDY OF PELVIC CANCER

Thursday, November 21, 1957, 5:00 to 6:00 p.m. — To be selected

OPHTHALMOLOGICAL SECTION, B. C. M. S.

Thursday, November 21, 1957
Cocktails and Dinner: 6:00 p.m. — Johns Hopkins Club
Scientific Meeting: 8:00 p.m.

JOINT COMMITTEE ON MATERNAL MORTALITY, CITY HEALTH DEPT. AND B. C. M. S.

Thursday, November 28, 4:00 p.m. — 1211 Cathedral Street

DISPOSITION OF UNUSED NARCOTICS

All drugs surrendered to the Bureau of Narcotics must be listed on Forms 142 (in quadruplicate), each copy must be signed in the space indicated and the drugs must be shipped to the District Supervisor, Bureau of Narcotics, at Room 318, Post Office Building, Baltimore, Maryland, by express prepaid. The Government makes no reimbursement for any drugs so surrendered.